

**LIMITATIONS ON AMOUNT
DURATION AND SCOPE OF SERVICES**

General Provisions Applicable to All Services:

Payment for Services Furnished Out-of-State

Out-of-state services, furnished in accordance with 42 CFR 431.52, are subject to the same prior approval and continued stay reviews that would be required if the services were rendered by an in-state provider, and must be subject to the utilization review and oversight requirements of the provider's home state Medicaid program.

In addition, out-of-state services provided in accordance with 42 CFR 431.52(2)(b)(iii) are subject to prior approval to go out of state.

In accordance with 42 CFR 431.52(2)(b)(iv), the state Medicaid agency will determine whether it is the general practice for recipients in a particular locality to use medical providers in another state.

Prior Approval

Prior approval is required for certain procedures, products, and services. The decision to require prior approval for a specific procedure, product or service and the requirements that must be met for prior approval are based on evaluation of the factors such as: utilization; efficacy; safety; potential risk to patients; potential for misuse or abuse; high cost; the availability of more cost effective or equivalent procedures, products and services; and legislative mandate. Specific prior approval requirements are published in Medicaid Clinical Coverage Policies on the NC Division of Medical Assistance website (www.dhhs.state.nc.us/dma/mp/mpindex.htm).

Retroactive prior approval for procedures, products, and services that require prior approval will not be permitted, except in cases where retroactive eligibility is established.

1. Inpatient General Hospital Services:

All medical services performed must be medically necessary and may not be experimental in nature. Medical necessity is determined by generally accepted North Carolina community practice standards as verified by independent Medicaid consultants.

- A. Prior approval is required for cosmetic surgery, bone marrow, and surgical transplants excluding bone, skin, corneal, kidney and autologous tendon transplants. Prior approval is based on medical necessity and state medical policy.
- B. Medical necessity for on-going inpatient general hospital services will be determined initially by a hospital's Utilization Review Committee and may be subject to post-payment review by the State Agency. All claims will be subject to prepayment review for Medicaid coverage.
- C. The State Agency may grant a maximum of three Administrative days to arrange for discharge of a patient to a lower level-of-care. With prior approval by the State Medicaid agency, the hospital may be reimbursed for days in excess of the three administrative days at the statewide average rate for the particular level of care needed in the event a lower level-of-care bed in a Medicaid approved health care institution is not available. The hospital must, however, make every effort to place the recipient in an appropriate institution within the three-day administrative time allowance.
- D. The following are non-covered services: telephone, television, or other convenience items not routinely provided to other patients.

Level of Care criteria for ventilator-dependent care is described in Appendix 4 of Attachment 3.1-A.

2.a. Outpatient Hospital Services

All medical services performed must be medically necessary and may not be experimental in nature. Medical necessity is determined by generally accepted North Carolina community practice standards as verified by independent Medicaid consultants.

- (1) Prior approval shall be required for each psychiatric outpatient visit after the eighth visit for recipients 21 years and over. The twenty-four (24) visit limitation per year does not apply to recipients 21 years and over receiving mental health services subject to utilization review. Approval will be based on medical necessity.
- (2) Prior approval shall be required for each psychiatric hospital outpatient visit after the 26th visit for recipients under age 21.
- (3) Routine physical examinations and immunizations are covered under Adult Health Screening and under Early Periodic Screening Diagnosis and Treatment (EPSDT).
- (4) "Take home drugs", medical supplies, equipment and appliances are not covered, except for small quantities of medical supplies, legend drugs or insulin needed by the patient until such time as the patient can obtain a continuing supply.

- (5) Injections are not covered if oral drugs are suitable.
- (6) Office visits (encounters) to one or a combination of physicians, clinics, hospital outpatient settings, chiropractors, podiatrists, and optometrists are limited to twenty-four (24) per recipient per State fiscal year. Additional visits in excess of the twenty-four (24) visit limit may be authorized by the State agency in emergency situations where the life of the patient would be threatened without such additional care. This limitation does not apply to EPSDT eligible children. This limitation does not apply to adults 21 and over receiving mental health services subject to independent utilization review.

2.b. Rural Health Clinic Services and other Ambulatory Services Furnished by a Rural Health Clinic

All medical services performed must be medically necessary and may not be experimental in nature. Medical necessity is determined by generally accepted North Carolina community practice standards as verified by independent Medicaid consultants.

- (1) Other ambulatory services provided by Rural Health Clinics are:
 - (a) Chiropractic services
 - (b) Dental Services
 - (c) Drugs, legend in insulin
 - (d) EPSDT
 - (e) Eyeglasses and visual aids
 - (f) Family Planning Services
 - (g) Hearing Aids
 - (h) Optometric Services
 - (i) Podiatry Services
- (2) Rural Health Clinic Services are subject to the limitations of the physicians' services program.
- (3) Office visits (encounters) to one or a combination of physicians, clinics, hospital outpatient settings, chiropractors, podiatrists and optometrists are limited to twenty-four (24) per recipient per State fiscal year. Additional visits in excess of the twenty-four (24) visit limit may be authorized by the State agency in emergency situations where the life of the patient would be threatened without such additional care. This limitation does not apply to EPSDT eligible children.

2.c. Federally Qualified Health Center (FQHC) services and other ambulatory services

Limitations are the same as in 2.b

3. .0104 Other laboratory and X-ray services

Laboratory and X-ray services shall be covered to the extent permitted in federal Medicaid regulations and subject to the following conditions:

- (1) The service is not performed in connection with a routine physical examination.
- (2) It is provided in an office or similar facility other than a hospital outpatient department or a clinic.
- (3) Clinical laboratory services are rendered by medical care entities who are issued a certificate of waiver, registration certificate, or certificate of accreditation under the Clinical Laboratories Improvement Amendments of 1988.
- (4) Portable X-ray services are medically necessary and ordered in writing by the attending physician. Services may be provided only by providers who are Medicare certified and inspected by the N.C. Division of Facility Services and are limited to provision in the patient's place of residence. The ordering physician must:
 - (a) State the patient's diagnosis, and
 - (b) Indicate the condition suspected, and
 - (c) Reason why "portable" service is needed.
- (5) Portable ultrasound services are medically necessary and ordered in writing by the attending physician. Providers must be Medicare certified as physiological labs, assure its personnel are licensed or registered in accordance with applicable State laws, and comply with manufacturer's guidelines for use of and routine inspection of equipment. The ordering physician must:
 - (a) State the patient's diagnosis, and
 - (b) Indicate the condition suspected, and
 - (c) Reason why "portable" service is needed

4.a. Skilled Nursing Facility Services

- (1) Prior approval is required. This approval is based on reporting form for each patient to be admitted to a skilled nursing facility signed by the attending physician which indicates anticipated restoration potential, treatments orders, and type of care recommended.

- (2) Where cases warrant expeditious action, telephone approvals can be obtained; these must be followed up with the completed reporting form indicated in (1) above.
- (3) Private accommodations are authorized only when directed by a physician as medically necessary or when all semi-private accommodations are occupied.
- (4) The items and services furnished in SNFs, ICFs, and ICF-MRs that are payable by the Medicaid Program when medically necessary and for which recipients may not be charged are listed below. Unless stated otherwise these services are payable only to long term care facilities.
 - (a) Semi-private room, ward accommodations or private room if medically necessary, including room supplies such as water pitchers, basins, and bedpans.
 - (b) Nursing staff services.
 - (c) Food and intravenous fluids or solutions.
 - (d) Linens and patient gowns and laundering of these items.
 - (e) Housekeeping services.
 - (f) Social services and activity programs.
 - (g) Physical therapy, speech therapy, audiology, occupational therapy, respiratory therapy, and all other forms of therapy.
 - (h) Medical supplies, oxygen, orthotics, prostheses and durable medical equipment.
 - (i) Non legend drugs, serums, vaccines, antigens, and antitoxins.
 - (j) Transportation to other medical providers for routine, non-emergency care.
 - (k) Laboratory and radiology services, payable to either the long term care facility or directly to the provider furnishing the service.
 - (l) Physician and dental services, payable only to the practitioners if provided in private facilities.
 - (m) Legend drugs and insulin payable only to pharmacies if provided in private facilities.
 - (n) Transportation to other medical providers for emergency care, payable only to ambulance providers.

The following items can be charged to recipients:

- (a) Customary room charge to reserve a room during a recipient's hospital stay, therapeutic leave in excess of the maximum allowed, and other absences.
- (b) Customary private room differential charge if a private room is not medically necessary.
- (c) Private duty nurse or attendants.
- (d) Telephone, television, newspaper, and magazines.
- (e) Guest meals.
- (f) Barber and beauty shop, services other than routine grooming required as part of the patient's care plan.
- (g) Personal clothing and laundry
- (h) Personal dental and grooming items.
- (i) Tobacco products
- (j) Burial services and items.

Level of Care criteria is described in Appendix 1 of Attachment 3.1-A.

Level of Care criteria for non acute intensive rehabilitation head-injury care described in Appendix 3 of Attachment 3.1-A

Level of Care criteria for ventilator-dependent care described in Appendix 4 of Attachment 3.1-A.

4.b. Early and Periodic Screening, Diagnosis and Treatment

- (1) Prior approval is required for hearing aids. The prior approval request must be supported by a medical evaluation and prescription from an otologist, otolaryngologist, or speech clinic affiliated with the outpatient department of a hospital. An audiogram must be included.

(2) Dental Services

Covers fillings, extractions, restorative services, stainless steel space maintainers, prophylaxes, scaling and curettage, fluoride, x-rays, relief of pain, periodontic services, complete and partial dentures with rebasing and relining, endodontic therapy on anterior teeth, surgery, and orthodontics.

(3) Dentures

Prior approval is required. Completed and partial dentures are allowed only once in a ten (10) year period. Where medical necessity may be a factor, individual consideration may be given. Standard materials and procedures are used for full and partial dentures. Initial relines of dentures may be reimbursed only if six (6) months have elapsed since receipt of dentures. Subsequent relines are allowed only at five (5) year intervals.

(4) Prosthetic and Orthotic Devices

Medically necessary orthotic and prosthetic devices are covered by the Medicaid program when prescribed by a qualified licensed healthcare practitioner and supplied by a qualified provider.

Only items determined to be medically necessary, effective and efficient are covered. Items which require prior approval are indicated by an asterisk beside the HCPCS code on the Orthotic and Prosthetic Fee Schedule. This fee schedule is located at www.dhhs.state.nc.us/dma/fee/fee.htm.

A qualified orthotic and prosthetic device provider must be approved by the Division of Medical Assistance. The provider requirements are published in Medicaid Clinical Coverage Policies on the NC Division of Medical Assistance website (www.dhhs.state.nc.us/dma/dme/5B.pdf).

Prior approval is required for certain orthotic and prosthetic devices. The decision to require prior approval for a specific procedure, product or service and the requirements that must be met for prior approval are based on evaluation of the factors such as: utilization; efficacy; safety; potential risk to patients; potential for misuse or abuse; high cost; the availability of more cost effective or equivalent procedures, products and services; and legislative mandate. High cost is cost in comparison to other covered items and related maintenance. Such a designation would usually be arrived at by a team of DMA staff from fiscal, programmatic and Program Integrity areas. Whether the recipient gets the item or not is dependent on the rationale for medical need and the unavailability of another less costly item that would adequately address the need. Session Law 2004-124 states "medically necessary prosthetics and orthotics are subject to prior approval and utilization review." Specific prior approval requirements are published in Medicaid Clinical Coverage Policies on the NC Division of Medical Assistance website (www.dhhs.state.nc.us/dma/dme/5B.pdf).

**Adult Orthotic and Prosthetic Information is located at: Attachment 3.1-A.1, Page 15.*

(5) Selected Services Are Covered

Selected services include physical, occupational, speech, language pathology/audiology, and respiratory therapy. Services include but are not limited to: inpatient hospital; nursing facilities; and outpatient services in physician offices and hospitals; and local management entities, as well as locations defined by clinical policies.

Prior to treatment a screening service provided by a practitioner licensed according to North Carolina General Statute Chapter 90 must document that the treatment is medically necessary to correct or ameliorate any defects or chronic conditions.

The amount, duration and scope of the services must be expected to correct or ameliorate any defects or chronic conditions according to the referring treatment plan of care. These services must be provided in the most economical setting available according to clinical policies and limitations promulgated in accordance with Session Law 2001-424.

(6) The above listed services are covered as follows:

Other Diagnostic Screening, Preventive and Rehabilitative Services are reimbursed in accordance with Attachment 4.19-B. Clinic services, Hospital Outpatient services, Home Health Agencies and Physician Services are also reimbursed in accordance with Attachment 4.19-B.

The agency assures that if there are providers involved whose payment is based on reasonable cost, the State will provide appropriate cost reimbursement methodologies. The agency has waived the 6 prescription limit and the 24 visit limit for ambulatory visits for EPSDT eligible clients. The agency will cover all diagnostic and treatment services listed in 1905(a) which are medically necessary to correct or lessen health problems detected during screening. These services will be made available based on individual client needs.

(7) Assurance 1905(a) Services

The state assures that EPSDT eligible clients have access to 1905(A) services not specifically listed in the state plan when they are medically necessary. Services provided as described in Section 1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by screening services and not covered in the state plan will be provided if determined to be medically necessary by the appropriate agency staff or consultants.

4.b(8) Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services

Services provided under this section are provided by licensed practitioners (within their scope of practice as determined by the North Carolina Practice Acts per discipline) or programs/agencies for the mentally ill and substance abusers certified as meeting the program standards of the Commission on Mental Health, Developmental Disabilities and Substance Abuse Services and directly enrolled by the Medicaid Agency. Staff of the agency providing services will also meet requirements set forth in Federal regulations or the requirements for one of the three categories described on pages 7c.10 and 7c.11. These services are available to categorically needy and medically needy recipients. Services include the following:

Medically necessary diagnostic evaluations or assessments (Diagnostic Assessment) identify the existence, nature and extent of illness. The services may include a systematic appraisal of mental, psychological, physical, behavioral, functional, social, economic and/or intellectual limitations and resources of the individual in order to determine the nature and extent of illness. This information will be used in the formulation of an individualized person centered plan for the recipient.

Other medically necessary diagnostic, screening, treatment, preventive and rehabilitative (ODSPR) services for the mentally ill and substance abusers are covered benefits when medically necessary. Screening services means the use of standardized tests given under medical direction. Diagnostic, preventive, or rehabilitative services must be ordered by a physician, licensed psychologist, physician's assistant or nurse practitioner practicing within the scope of his/her practice according to Chapter 90 of the North Carolina General Statutes.

Covered services are provided to recipients in their residence or in a community setting, which may be any location other than in a public institution (IMD), other inpatient setting, jail or detention facility.

Inpatient psychiatric facilities serving individuals under age 21 will meet the requirement of 42 Code of Federal Regulations Part 441, Subpart D, and Part 483, Subpart G.

The following services will be covered when a determination is made that the services are medically necessary and will meet specific behavioral health needs of the recipient. Specific services must correct or ameliorate diagnosable conditions or prevent the anticipated deterioration of the patient's condition. Services provided to family members of the recipient must be related to the recipient's mental health/substance abuse disability.

Covered services for EPSDT children include but are not limited to: Evaluation/Assessments/Psychotherapy/Behavioral Health Counseling, Diagnostic Assessment, Community Supports Child, Day Treatment, Partial Hospital, Mobile Crisis Management, Intensive In Home, Multisystemic Therapy, Substance Abuse Intensive Outpatient, and Ambulatory Detoxification.

4.b.(8) Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services (continued)
Description of Services

(a) Evaluation/Assessments/ Psycho-therapy/Behavioral Health Counseling
For the complete description of the service, see Attachment 3.1-A.1 pages 7c.11 and 7c.12.

(b) Diagnostic Assessment (42 CFR 430.130(a))

This is a clinical face to face evaluation of a recipient's mh/dd/sas condition that will establish a need for the enhanced benefit package of services. It is a team service and must include evaluations by either, a physician, physician assistant, nurse practitioner or licensed psychologist who can sign an order for services and a licensed or certified practitioner with expertise in mh/dd/sas as appropriate and consist of the following:

- a chronological general health and behavioral health history (includes both mental health and substance abuse) of the recipient's symptoms, treatment, treatment response and attitudes about treatment over time, emphasizing factors that have contributed to or inhibited previous recovery efforts; biological, psychological, familial, social, developmental and environmental dimensions and identified strengths and weaknesses in each area;
- a description of the presenting problems, including source of distress, precipitating events, associated problems or symptoms, recent progressions, and current medications;
- a strengths/problem summary which addresses risk of harm, functional status, co-morbidity, recovery environment, and treatment and recovery history;
- diagnoses on all five (5) axes of DSM-IV;
- evidence of an interdisciplinary team progress note that documents the team's review and discussion of the assessment;
- a recommendation regarding target population eligibility; and
- evidence of recipient participation including families, or when applicable, guardians or other caregivers.

Documentation must include the following elements:

- a chronological general health and behavioral health history (includes both mental health and substance abuse) of the recipient's symptoms, treatment, treatment response and attitudes about treatment over time, emphasizing factors that have contributed to or inhibited previous recovery efforts; biological, psychological, familial, social, developmental and environmental dimensions and identified strengths and weaknesses in each area;
- a description of the presenting problems, including source of distress, precipitating events, associated problems or symptoms, recent progressions, and current medications;
- strengths/problem summary which addresses risk of harm, functional status, co-morbidity, recovery environment, and treatment and recovery history;
- diagnoses on all five (5) axes of DSM-IV;
- evidence of an interdisciplinary team progress note that documents the team's review and discussion of the assessment;
- a recommendation regarding target population eligibility; and
- evidence of recipient participation including families, or when applicable, guardians or other caregivers.

A recipient may receive one diagnostic assessment per year without any additional authorization.

4.b.(8) Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services (continued)
Description of Services

(c) Community Supports Child (CS) (CFR 42 430.130(d))

This service is available to children from age 3 through age 20 and will become the “clinical home” for mental health/substance abuse services (similar to a medical home for medical services) for the child. NOTE: Services for children from age 0 to age 3 can be found at Attachment 3.1-A.1 page 7g.1 “*Early Intervention Rehabilitative Services*.” The interventions carried out by a Qualified Professional, a Certified Clinical Supervisor or a Certified Clinical Addictions Specialist is as follows:

- coordination and oversight of initial and ongoing assessment activities,
- initial developmental and ongoing revision of an individualized treatment plan, a person centered plan (PCP),
- monitoring implementation of PCP; and
- other case management functions of linking and referring.

The interventions carried out by an associate professional or a paraprofessional, include:

- training of the care giver,
- preventive, and therapeutic activities that will assist with skill building ,
- relational skills,
- symptom monitoring,
- therapeutic mentoring; and
- behavior and anger management.

The service must be ordered by a physician, licensed psychologists, physician’s assistant or nurse practitioner. The providers of this service will also serve as a “first responder” in a crisis situation. The service will be provided as an agency based service with qualified professionals, paraprofessionals and associate professionals, who must have 20 hours of training specific to the requirements of the service definition within the first 90 days of employment. Clinical criteria (medical necessity criteria for admission and continued services) are contained in the definition. Documentation must include: a service note that includes the recipient’s name, Medicaid identification number, date of service, purpose of contact, describes the provider’s interventions, includes the time spent performing the interventions, effectiveness of the intervention, the signature and credentials of the staff providing the service. There are limitations indicated to prevent this service from being provided while a child is an inpatient or receiving residential treatment, or an intensive in-home service, MST or intensive substance abuse service with the exception of 8 units per months in the case management component of the service. Prior approval will be required via the statewide UR vendor or by an approved LME contracted with the Medicaid Agency and meeting the same standards and requirements as the statewide vendor. This initial prior approval process will ensure that the level of the service is appropriate and concurrent reviews will determine the ongoing medical necessity for the service or the need to move up or down the continuum of services to another level of care.

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4.b.(8) Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services (continued)
Description of Services

(d) Mental Health Day Treatment

This service is available for children from age 3 up through age 20 and includes therapeutic or rehabilitation goals of the consumer in a structured setting. NOTE: Services for children from age 0 to age 3 can be found at Attachment 3.1-A.1 page 7g.1 “*Early Intervention Rehabilitative Services.*” This is an existing service which has been modified to increase provider qualifications, require additional training for providers and require prior authorization. The interventions are outlined in the child/adolescent person centered treatment plan and may include:

- behavioral interventions,
- social and other skill development,
- communication enhancement,
- problem- solving skills,
- anger management,
- monitoring of psychiatric symptoms; and
- psycho-educational activities as appropriate.

These interventions are designed to support symptom stability, increase the recipient’s ability to cope and relate to others and enhancing the highest level of functioning possible. The service will also contain a case management component with assessment, monitoring, linking to services and coordination of care.

Documentation must include: a daily full service note that includes the recipient’s name, Medicaid identification number, date of service, purpose of contact, describes the provider’s interventions, includes the time spent performing the interventions, effectiveness of the intervention, and the signature of the staff providing the service. This service must be available three hours a day minimally in a licensed program. All services in the milieu are provided by a team which may have the following configuration; providers meet the “Q” requirements, associate professionals and paraprofessionals. The service must be ordered by a physician, licensed psychologists, physician’s assistant or nurse practitioner and prior approval will be required via the statewide UR vendor or by an approved LME, contracted with the Medicaid Agency and meeting the same standards and requirements as the statewide vendor. This initial prior approval process will ensure that the level of the service is appropriate and concurrent reviews will determine the ongoing medical necessity for the service or the need to move up or down the continuum of services to another level of care.

This service can only be provided by one day treatment provider at the time and cannot be billed on the same day as any inpatient, residential, or any other intensive in home service.

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4.b.(8) Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services (continued)
Description of Services

(e) Partial Hospital (PH)

This is a short term service for acutely mentally ill children which provides a broad range of intensive therapeutic approaches which may include:

- Individual/group therapies,
- Increase the individual's ability to relate to others,
- Community living skills/training,
- Coping skills,
- Medical services; and
- This is used as a step up to inpatient or a step down from inpatient.

Physician involvement is required. This service must be offered at a minimum of 4 hours per day, 5 days/week. Clinical criteria (medical necessity criteria for admission and continued stay) are embedded in the service definition. Documentation must include: a daily full service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, describes the provider's interventions, includes the time spent performing the interventions, effectiveness of the intervention, and the signature of the staff providing the service. The service must be ordered by a physician, licensed psychologists, physician's assistant or nurse practitioner and prior approval will be required via the statewide UR vendor or by an approved LME contracted with the Medicaid Agency and meeting the same standards and requirements as the statewide vendor. This initial prior approval process will ensure that the level of the service is appropriate and concurrent reviews will determine the ongoing medical necessity for the service or the need to move up or down the continuum of services to another level of care.

(f) Mobile Crisis Management

This involves all supports, services and treatments necessary to provide integrated crisis response, crisis stabilization interventions and crisis prevention activities. It is available 24/7/365 and provides immediate evaluation, triage and access to acute mh/dd/sas services, treatment, supports to effect symptom reduction, harm reduction and/or to safely transition persons in acute crisis to the appropriate environment for stabilization. It is provided by a team that includes a Qualified Professional who must be either, a nurse, a clinical social worker or psychologist. Teams include substance abuse professionals, and a psychiatrist must be available for face to face or telephone consults. Paraprofessionals with crisis management experience may also be included on the team but must work under the supervision of a professional. Experience with the appropriate disability group is required and 20 hours of crisis intervention training within the first 90 days of employment is necessary. The maximum length of the service is 24 hours per episode and prior authorization will be required after the first 8 hours for the remaining 16 hours. Documentation must include: a service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, describes the provider's interventions, includes the time spent performing the interventions, effectiveness of the intervention, and the signature of the staff providing the service.

NOTE: This has a limitation; however the service requires stabilization or movement into an environment that can stabilize so it is not really a termination of service.

4.b.(8) Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services (continued)
Description of Services

(g) Intensive In-Home

A time limited mental health/substance abuse service that can be provided through age 20 in order to:

- diffuse current crisis as a first responder,
- intervene to reduce likelihood of re-occurrence,
- ensure linkage to community services and resources,
- monitor and manage presenting psychiatric and/or addictions,
- provide self-help and living skills for youth; and
- work with caregivers in implementation of home-based supports and other rehabilitative supports to prevent out of home placement for the child.

This is a team service provided by qualified professionals, associate professionals and paraprofessionals. There is a team to family ratio to keep case load manageable and staff must complete intensive in home training within the first 90 days of employment. Services are provided in the home or community and not billable for children in detention or inpatient settings. The service requires a minimum of 12 face to face contacts the first month with a contact being defined as all visits within a 24 hour period. A minimum of 2 hours of service must be provided each day for the service to be billable. Number of visits per month for the second and third month of the service will be titrated with the expectation of six visits per month. Documentation must include: a daily full service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, describes the provider's interventions, includes the time spent performing the interventions, effectiveness of the intervention, and the signature of the staff providing the service. The service must be ordered by a physician, licensed psychologists, physician's assistant or nurse practitioner and prior approval will be required via the statewide UR vendor or by an approved LME contracted with the Medicaid Agency and meeting the same standards and requirements as the statewide vendor. This initial prior approval process will ensure that the level of the service is appropriate and concurrent reviews will determine the ongoing medical necessity for the service or the need to move up or down the continuum of services to another level of care.

There are limitations on the provisions of other services to prevent duplication.

4.b.(8) Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services (continued)
Description of Services

(h) Multisystemic Therapy (MST)

This mental health/substance abuse program is designed for youth generally between the ages of 7 and 17 who have antisocial, aggressive/violent behaviors and are at risk for out of home placement due to delinquency; adjudicated youth returning from out of home placement and/or chronic or violent juvenile offenders; and youths with serious emotional disturbances or abusing substances. This is a team service that has the ability to provide service 24/7/365. The services include assessment, individual therapeutic interventions with the youth and family, case management, and crisis stabilization. Specialized therapeutic interventions are available to address special areas such as substance abuse, sexual abuse, sex offending, and domestic violence. The service must be ordered by a physician, licensed psychologists, physician's assistant or nurse practitioner and prior approval will be required via the statewide UR vendor or by an approved LME contracted with the Medicaid Agency and meeting the same standards and requirements as the statewide vendor. This initial prior approval process will ensure that the level of the service is appropriate and concurrent reviews will determine the ongoing medical necessity for the service or the need to move up or down the continuum of services to another level of care.

A minimum of 12 contacts are required within the first month of the service and for the next two months an average of 6 contacts per month will occur. It is the expectation that service frequency will be titrated over the last two months. Documentation must include: a daily full service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, describes the provider's interventions, includes the time spent performing the interventions, effectiveness of the intervention, and the signature of the staff providing the service.

Clinical criteria (medical necessity criteria for admission and continued stay) are embedded in the service definition. The provider qualifications are at a minimum a master's level QP who is the team supervisor and three QP staff. Staff is required to participate in MST introductory training and quarterly training on topics related to the needs of MST youth and their family on an ongoing basis. All MST staff shall receive a minimum of one hour of group supervision and one hour of telephone consultation per week from specially trained MST supervisors. Limitations are in place to prevent reimbursement for duplication of services.

4.b.(8) Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services (continued)
Description of Services

(i) Substance Abuse Intensive Outpatient (SAIOP)

This service provides motivational enhancement and engagement therapies for recovery, random alcohol/ drug testing and strategies for relapse prevention to include community and/or other strategies for relapse preventions. These therapies include:

- Individual counseling and support,
- Group counseling and support,
- Family counseling and support,
- Biochemical assays to identify recent drug use (e.g. urine drug screens),
- Strategies for relapse prevention: community and social support systems in treatment,
- Crisis contingency planning,
- Disease management; and
- Treatment support activities that have been adapted or specifically designed for persons with physical disabilities or persons with co-occurring disorders of mental illness and/or developmental disabilities and/or substance abuse/dependence.

SAIOP must be available for a minimum of 3 hours per day, be operated out of a licensed substance abuse facility and can be provided in a variety of settings. The maximum face to face ratio is an average of not more than 12 recipients to 1 direct services staff based on average daily attendance. Documentation must include: a service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, describes the provider's interventions, includes the time spent performing the interventions, effectiveness of the intervention, and the signature of the staff providing the service. This service can only be provided by qualified substance abuse professional staff with the following licenses or certifications: Licensed Psychological Associates, Licensed Professional Counselors, Licensed Clinical Social Workers, Certified Substance Abuse Counselors, and Licensed Clinical Addiction Specialists. This service must be ordered by an MD, NP, PA or PhD psychologist. Prior approval will be required via the statewide UR vendor or by an approved LME contracted with the Medicaid Agency and meeting the same standards and requirements as the statewide vendor. This initial prior approval process will ensure that the level of the service is appropriate and concurrent reviews will determine the ongoing medical necessity for the service or the need to move up or down the continuum of services to another level of care.

4.b.(8) Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services (continued)
Description of Services

(j) Ambulatory Detoxification

Ambulatory Detoxification is an organized service delivered by trained practitioners who provide medically supervised evaluations, detoxification and referral services according to a predetermined schedule. These services are provided in a licensed facility with regularly scheduled sessions by a CCS, LCAS, QP or AP. Documentation must include: a service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, describes the provider's interventions, includes the time spent performing the interventions, effectiveness of the intervention, and the signature of the staff providing the service. A physician is available 24/7 to conduct an assessment within 24 hours of admission. A registered nurse is available to conduct a nursing assessment on admission and oversee the monitoring of patient's progress and medications. This service must be ordered by an MD, NP, PA or PhD psychologist. Prior approval will be required via the statewide UR vendor or by an approved LME contracted with the Medicaid Agency and meeting the same standards and requirements as the statewide vendor. This initial prior approval process will ensure that the level of the service is appropriate and concurrent reviews will determine the ongoing medical necessity for the service or the need to move up or down the continuum of services to another level of care.

4.b.(9) Behavioral Health Rehabilitative Services (continued)

(d) Provider Qualifications for Staff Employed by Agencies Enrolled with Medicaid

Providers will meet either the appropriate Federal regulations or the requirements for one of the three categories described on pages 7c.10 and 7c.11.

- i) Paraprofessional
“Paraprofessional” within the mental health and substance system means an individual who has a GED or high school diploma (or no GED or high school diploma if employed prior to November 1, 2001). Supervision shall be provided by a qualified professional or associate professional with the population served.
- ii) Associate Professional (AP)
“Associate Professional” within the mental health and substance abuse services system means an individual who is a:
 - graduate of college or university with a Masters degree in a human service field and less than one year of full time post-graduate mental health or substance abuse experience with the population served or a substance abuse professional with less than one year of full-time, post-graduate degree supervised experience in alcoholism and drug abuse counseling. Supervision shall be provided by a qualified professional with the population served until the individual meets one year of experience; or
 - graduate of college or university with a bachelor’s degree in a human service field with less than two years of full-time post-bachelor’s degree mental health or substance abuse experience with the population served, or a substance abuse professional with less than two years post bachelor’s degree accumulated supervised experience in alcoholism and drug abuse counseling. Supervision shall be provided by a qualified professional with the population served until the individual meets two years of experience; or
 - graduate of a college or university with a bachelor’s degree in a field other than human services with less than four years of full-time, post bachelor’s degree accumulated supervised experience in mental health or substance abuse with the population served. Supervision shall be provided by a qualified professional with the population served until the individual meets four years of experience; or
 - registered nurse who is licensed to practice in the State of North Carolina by the North Carolina Board of Nursing with less than four years of full-time accumulated experience in mental health or substance abuse with the population served. Supervision shall be provided by a qualified professional with the population served until the individual meets four years of experience.

4.b.(9) Behavioral Health Rehabilitative Services (continued)

(d) Provider Qualifications for Staff Employed by Agencies Enrolled with Medicaid

(iii) Qualified Professional (QP)

“Qualified Professional” within the mental health and substance abuse system means:

- an individual who holds a license, provisional license, certificate, registration or permit issued by the governing board regulating a human service profession, except a registered nurse who is licensed to practice in the State of North Carolina by the North Carolina Board of Nursing, who also has four years of full-time accumulated experience in mh/sa with the population served; or
- a graduate of a college or university with a Masters degree in a human service field and one year of full-time, post-graduate degree experience with the population served or a substance abuse professional with one year of full-time, post-graduate degree accumulated supervised experience in alcoholism and drug abuse counseling; or
- a graduate of college or university with a bachelor’s degree in a human service field and two years of full-time, post-bachelor’s degree experience with the population served or a substance abuse professional who has two years full-time, post-bachelor’s degree accumulated supervised alcoholism and drug abuse counseling; or
- a graduate of a college or university with a bachelor’s degree in a field other than human services with four years of full-time, post-bachelors degree accumulated mh/sa experience with the population served.

This category includes Substance Abuse Professional, Certified Substance Abuse Counselors (CSAC), Certified Clinical Supervisor (CCS), Licensed Clinical Addictions Specialist (LCAS) *

The full descriptions of categories of providers are found in the North Carolina Administrative Code

Supervision is provided as described below:

Covered services are provided to recipients by agencies directly enrolled in the Medicaid program which employ qualified professionals, associate professional and paraprofessionals. Medically necessary services delivered by associate and paraprofessionals are delivered under the supervision and direction of the qualified professional. The qualified professional personally works with consumers to develop the person centered individualized treatment plan and meets with consumers periodically during the course of treatment to monitor the services being delivered and to review the need for continued services. The supervising qualified professional assumes professional responsibility for the services provided by associate and paraprofessionals and spends as much time as necessary directly supervising services to ensure that recipients are receiving services in a safe and efficient manner in accordance with accepted standards of practice. The terms of the qualified professional’s employment with the directly enrolled agency providing service ensures that the qualified professional is adequately supervising the associate and paraprofessionals. The agencies ensure that supervisory ratios are reasonable and ethical and provide adequate opportunity for the qualified professional to effectively supervise the associate and paraprofessional staff assigned. Documentation is kept to support the supervision provided to associate and paraprofessional staff in the delivery of medically necessary services.

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4.b.(9) Rehabilitative Services for Behavioral Health of EPSDT Eligible

- (a) The agency assures that if there are providers involved whose payment is based on reasonable cost, the State will provide appropriate cost reimbursement methodologies. Services are reimbursed in accordance with Attachment 4.19-B.
- (b) Services may be provided by: Licensed or certified psychologists, licensed clinical social workers, certified clinical nurse specialists in psychiatric mental health advanced practice, nurse practitioners certified in psychiatric mental health advanced practice, licensed psychological associates, licensed professional counselors, licensed marriage and family therapists, certified/licensed clinical addictions specialists, and certified/licensed clinical supervisors, when Medicaid-eligible children are referred by the Community Care of North Carolina primary care physician, a Medicaid enrolled psychiatrist, or the area mental health program or local management entity. Prior approval shall be required for each psychiatric outpatient visit after the 26th visit each calendar year for recipients under age 21.

4.b.(9) Rehabilitative Services for Behavioral Health of EPSDT Eligible (*continued*)

- (c) Services under this section are provided by licensed practitioners or programs/agencies for the mentally ill, developmentally disabled and substance abusers, certified/licensed as clinical addictions specialist (CCAS) and clinical supervisors (CCS) meeting the program standards of the Commission on Mental Health, Developmental Disabilities and Substance Abuse Services; and who are directly enrolled with Medicaid. These services are available to categorically needy and medically needy recipients. They are also provided under a sunset clause by certified or privileged staff of Local Management Entities (LME) directly enrolled with Medicaid. Services include the following:
- (i) Outpatient Psychotherapy (billed under CPT codes 90801 through 90857) found in the psychiatric code section of the CPT book. Service can be billed by all licensed clinicians according to their scope of practice.
 - (ii) Psychological Testing, Developmental Testing, and Neuro-behavioral Testing (described in section/billed under CPT codes 96100 through 96117). Services can only be billed by PhD and Master's Level Psychologist.
 - (iii) Behavioral Health Assessment* and Counseling as described in the HCPCS book, under the following codes:
 - H0031 (a non-physician assessment),
 - H0004 with multiple modifiers (modifiers are added to match CPT codes for group counseling, and for family therapy), and
 - H0005 (substance abuse group counseling).

** CCAS and CCS can only bill for the three HCPCS codes as identified above.*

(8) Health Related Services Provided By Local Education Agency (LEA) Programs (ages 3 through 20)

(a) Audiology

Services must be medically necessary and appear in the child's Individualized Education Plan. Covered services include:

Assessment services:

Service may include testing and/or clinical observation as appropriate for chronological or developmental age for one or more of the following areas of functioning, and shall yield a written report:

Auditory sensitivity, including pure tone air and bone conduction, speech detection, and speech reception thresholds, auditory discrimination in quiet and noise, impedance audiometry including tympanometry and acoustic reflex, hearing aid evaluation, central auditory function and auditory brainstem evoked response

Treatment services:

Service may include one or more of the following as appropriate:

Auditory training, speech reading and augmentative communication

Qualifications of Providers: Providers must meet the applicable requirements of 42 CFR 440.110. A provider shall have

1. a valid license issued by the Board of Examiners for Speech and Language Pathologists and Audiologists, and
2. a Certificate of Clinical Competence (CCC) from the American Speech and Hearing Association;
 - A. have completed the equivalent educational requirements and work experience necessary for the CCC, or
 - B. have completed the academic program and is acquiring the supervised work experience to qualify for the CCC.

(b) Occupational Therapy

Services must be medically necessary and appear in the child's Individualized Education Plan. Covered services include:

Assessment services

Service may include testing and/or clinical observation as appropriate for chronological or developmental age for one or more of the following areas of functioning, and shall yield a written report:

Activities of daily living assessment, sensorimotor assessment, neuromuscular assessment, fine motor assessment, feeding/oral motor assessment, visual perceptual assessment, perceptual motor development assessment, musculo-skeletal assessment, gross motor assessment, functional mobility assessment, pre-vocational assessment

Treatment services

Service may include one or more of the following as appropriate:

Activities of daily living training, sensory integration, neuromuscular development, muscle strengthening, and endurance training, feeding/oral motor training, adaptive equipment application, visual perceptual training, facilitation of gross motor skills, facilitation of fine motor skills, fabrication and application of splinting and orthotic

devices, manual therapy techniques, sensorimotor training, pre-vocational training, functional mobility training, perceptual motor training.

Qualifications of Providers:

Providers must meet the applicable requirements of 42 CFR 440.110. Occupational therapy assessment services must be provided by a licensed occupational therapist.

Occupational therapy treatment services must be provided by a licensed occupational or a licensed occupational therapist assistant under the supervision of a licensed occupational therapist.

(c) Physical Therapy Services

Services must be medically necessary and appear in the child's Individualized Education Plan. Covered services include:

Assessment services

Service may include testing and/or clinical observation as appropriate for chronological or developmental age for one or more of the following areas of functioning, and shall yield a written report:

Neuromotor assessment, range of motion, joint integrity and functional mobility, flexibility assessment, gait, balance, and coordination assessment, posture and body mechanics assessment, soft tissue assessment, pain assessment, cranial nerve assessment, clinical electromyographic assessment, nerve conduction, latency and velocity assessment, manual muscle test, activities of daily living assessment, cardiac assessment, pulmonary assessment, sensory motor assessment and feeding/oral motor assessment

Treatment services

Service may include one or more of the following as appropriate:

Manual therapy techniques, fabrication and application of orthotic devices, therapeutic exercise, functional training, facilitation of motor milestones, sensory motor training, cardiac training, pulmonary enhancement, adaptive equipment application, feeding/oral motor training, activities of daily living training, gait training, posture and body mechanics training, muscle strengthening, gross motor development, modalities, therapeutic procedures, hydrotherapy, manual manipulation

Qualifications of Providers:

Providers must meet the applicable requirements of 42 CFR 440.110. Physical therapy assessment services must be provided by a licensed physical therapist. Physical therapy treatment services must be provided by a licensed physical therapist or a licensed physical therapist assistant under the supervision of a licensed physical therapist.

(d) Psychological Services

Services must be medically necessary and appear in the child's Individualized Education Plan. Covered services include:

Assessment services

Service may include testing and/or clinical observation as appropriate for chronological or developmental age for one or more of the following areas of functioning, and shall yield a written report:

Cognitive, emotional/personality, adaptive behavior, behavior and perceptual or visual motor

Treatment services

Service may include one or more of the following as appropriate:

Cognitive-behavioral therapy, rational-emotive therapy, family therapy, individual interactive psychotherapy using play equipment, physical devices, language interpreter or other mechanisms of non verbal communication and sensory integrative therapy

Qualifications of Providers:

Minimum qualifications for providing services are licensure as a psychological associate or practicing psychologist by the North Carolina State Board of Examiners of Practicing Psychologists, or certification as a school psychologist by the NC Department of Public Instruction, and Licensed Clinical Social Workers. Licensed Clinical Social Workers and Licensed Psychologists must be able to provide documentation of appropriate training and experience, which qualified them to work with students in an educational setting.

(e) Speech

Services must be medically necessary and appear in the child's Individualized Education Plan. Covered services include:

Assessment services

Service may include testing and/or clinical observation as appropriate for chronological or developmental age for all the following areas of functioning and shall yield a written report:

Receptive and expressive language, auditory memory, discrimination, and processing, vocal quality and resonance patterns, phonological development, pragmatic language, rhythm/fluency, oral mechanism, swallowing assessment, augmentative communication and hearing status based on pass/fail criteria

Treatment services

Service includes one or more of the following as appropriate:

Articulation therapy, language therapy; receptive and expressive language, augmentative communication training, auditory processing, discrimination, and training, fluency training, disorders of speech flow, voice therapy, oral motor training; swallowing therapy and speech reading.

Qualifications of Providers: Providers must meet the applicable requirements of 42 CFR 440.110. Clinicians must have the following credentials:

1. a valid license issued by the Board of Examiners for Speech and Language Pathologists and Audiologists, and
2. a Certificate of Clinical Competence (CCC) from the American Speech and Hearing Association;
 - A. have completed the equivalent educational requirements and work experience necessary for the CCC, or
 - B. have completed the academic program and is acquiring the supervised work experience to qualify for the CCC.

Treatment services may be performed by a Speech/Language Pathology assistant who works under the supervision of an enrolled licensed practitioner.

A provider shall perform services within the scope of practice of speech pathology as defined by G.S. 90-293 as interpreted by the courts.

- (9) Medicaid-eligible children from birth to age three who are referred to and/or determined to be eligible for the NC Infant-Toddler Program under Part C of the Individuals with Disabilities Education Act (IDEA) are eligible for services through the Children's Developmental Service Agency (CDSA). The CDSA is the local lead agency for the NC Infant-Toddler Program. At the request of the Local Education Agency (LEA), the CDSA may perform evaluations on Preschoolers (age 3, 4 and 5). For children who are transitioning from the NC Infant-Toddler Program to Preschool services, eligibility may extend beyond the third birthday as long as there is a time-limited transition plan in place.

The following federally mandated services are provided under the IDEA, covered when medically necessary and the service is outlined in the child's Individual Family Service Plan (IFSP).

- (a) Services include:
- Audiological: services to identify children with auditory impairment, using at risk criteria and appropriate audiologic evaluation procedures to determine the range, nature, and degree of hearing loss and communication functions. It includes referral for medical and other services necessary for the rehabilitation, provision of auditory training and aural rehabilitation, and determination of the child's need for amplification and its selection, use, and evaluation.
- Nutrition: services that include conducting nutritional assessments, developing and monitoring appropriate plans to address the nutritional needs of the child, based on the findings of the nutritional assessment, and making referrals to appropriate community resources to carry out nutritional goals.
- Occupational Therapy: services to address the functional needs of a child related to adaptive development, adaptive behavior and play, and sensory, motor, and postural development to improve the child's functional ability to perform tasks, including identification, assessment, intervention, adaptation of the environment, and selection of assistive and orthotic devices.
- Physical Therapy: services to address the promotion of sensorimotor function through enhancement of musculoskeletal status, neurobehavioral organization, perceptual and motor development, cardiopulmonary status, and effective environmental adaptation. It includes evaluation to identify movement dysfunction, obtaining, interpreting and integrating information for program planning and treatment to prevent or compensate for functional problems.

Psychological: services are administering psychological and developmental tests, interpreting results, obtaining and integrating information about the child's behavior, child and family conditions related to learning, mental health and development, and planning and managing a program of psychological services, including psychological counseling, family counseling, consultation on child development, parent training and education programs.

Speech/Language: services to identify children with communicative or oropharyngeal disorders and delays in communication skills development, referral for medical or other professional services and the provision of services necessary for their rehabilitation.

Medical: services for diagnostic or evaluation purposes only, services provided by a licensed physician to determine a child's developmental status and need for early intervention services.

Clinical Social Work: services are evaluation of a child's living conditions and patterns or parent-child interaction, preparing a social or emotional assessment of the child within the family context, counseling parents and other family members, appropriate social skill-building with the child and parents, working with those problems in the child's living situation, and identifying community resources to enable the child and family to receive maximum benefit from services.

Multidisciplinary Evaluations and Assessments: services are screening, evaluation, and assessment procedures used to determine a child's initial and continuing eligibility for Early Intervention services, the child's level of functioning in the developmental domains, and a medical perspective on the child's development. This service is used to determine the child's strengths and needs and services appropriate to meet those needs, and the resources and concerns of the family and the supports and services necessary to enhance the family's capacity to meet their child's developmental needs.

(b) Other covered services when deemed medically necessary include:

1. Early Intervention Rehabilitative Services

Rehabilitative Services for Infants and Toddlers include a range of coordinated services provided to a child less than 4 years of age in order to correct, reduce, or prevent further deterioration of identified deficits in the child's mental or physical health. They can also be targeted at restoring the developmental capacity of children who are felt to be at risk for such deficits because of specific medical, biological, or environmental risk factors. Children under three must meet all eligibility for early intervention services delineated in the "North Carolina Infant and Toddler Manual."

For children who are transitioning from the NC Infant-Toddler Program to Preschool services, eligibility for this service may extend beyond the child's third birthday as long as there is a time-limited transition plan in place. Four year olds may be served only under the following condition:

- the child is eligible for preschool special education services but community based rehabilitation services are needed to maintain skills during the transition period prior to the initiation of the preschool special education services through the IEP

Deficits are identified through comprehensive screening, assessments, and evaluations. Recommended services must be face-to-face encounters, medically necessary, within the scope of practice of the provider, and intended to maximize reduction of identified disability (ies) or deficit (s) and restoration of a recipient to his best possible functional level. Services include provision of direct hands-on treatment with the child and provision of collaboration with and instruction to parents and to caregivers in assisting in identifying, planning and maintaining a regimen related to regaining the child's functioning. Services may be provided in clinical settings, home, day care center, or other natural environment locations.

Provision of services where the family or caregivers are involved must be directed to meeting the identified child's medical treatment needs. Services provided to non-Medicaid eligible family members independent of meeting the identified needs of the child are not covered by Medicaid. Services must be ordered by and under the direction of a physician or licensed practitioner of the healing arts.

An eligible provider must enroll with the Divisions of Public Health and Medical Assistance as a Medicaid individual provider or group provider that employs or contracts with staff who hold a valid and active license in full force and effect to practice in the state of North Carolina, or a healing arts professional who meets the certification requirements for the Infant Toddler and Family Specialist (ITFS) as delineated in the "North Carolina Infant Toddler Program Procedures for Personnel Certification." The North Carolina Division of Public Health, through the Children's Developmental Services Agencies (CDSAs), documents and verifies the qualifications, training, and certification of the ITFS, verifies the valid licensure status, and recommends the provider for Medicaid participation. An eligible provider must be a licensed psychologist, licensed clinical social worker, licensed marriage and family counselor, or a qualified mental health professionals (QMHP), or a qualified developmental disability professional (QDDP) with ITFS certification. Paraprofessionals may also be providers if they

meet the certification requirements for Infant Toddler and Family Associate as delineated in the “North Carolina Infant Toddler Program Procedures for Personnel Certification and they are under the direct supervision of a professional certified according to these procedures. All providers of this service must possess the ITFS certification or be working toward certification at the required rate.

Rehabilitative services include the following range of services, referred to as early intervention services, to be provided to all eligible children less than 4 years of age for who all services are medically necessary:

- **Screening Services:** This is an interdisciplinary screen of standardized tests, the purpose of which is to identify those children who may require further evaluation and assessment. Planning for screening must occur under the medical direction of the CDSA and be carried out by the Medicaid provider. The component (s) of the screening performed must be within the scope of practice of the provider. Screenings are limited to three per recipient during the time determining eligibility and during time of eligibility.
- **Diagnostic/Evaluation Services:** This is either an initial or follow-up evaluation to determine a child’s level of functioning in each of the following developmental domains: (1) gross motor; (2) fine motor; (3) communication; (4) self-help and self-care; (5) social and emotional development; and (6) cognitive skills. The determination process includes the families’ perspective on the capacity of the child in these developmental domains and their concerns, priorities and resources related to this capacity.

The initial evaluation is limited to one per recipient. Follow-up evaluations are limited to three per year per recipient. Evaluations must be recommended by a licensed healing arts professional or certified ITFS.

- **Group and Individual Treatment Sessions:** These services are provided for the purpose of providing behavioral and developmental services in order to reduce the child’s mental or developmental disability or deficit as it relates to the developmental delay(s) identified within a domain(s) or restore /sustain the capacity of the child in these domains.
- **Community Based Rehabilitative Services:** This service is provided to meet the cognitive, communication, social/emotional and adaptive development needs of the child.

Cognitive – This refers to the acquisition, organization and ability to process and use information.

The ITFS, in consultation with the IFSP team, will work with caregivers on planning and developing individualized intervention strategies for the child to extend opportunities to practice thinking, problem solving and information processing skills into everyday activities in the home, daycare or other community setting. The ITFS will demonstrate and teach the intervention strategies to caregivers. Example goals could encompass; developing strategies for the child to understand cause and effect, object permanence, concepts of in and out, differentiating shapes and colors, associating movement with sound and establishing awareness of self and control of the environment, developing strategies to improve the child's visual tracking, eye contact, responding to reprimands and tone of voice, and following simple directions.

Communication – This includes expressive and receptive communication skills, both verbal and non-verbal.

The ITFS, in consultation with the IFSP team, will work with caregivers on planning and developing individualized intervention strategies for the child to extend language stimulation into everyday activities in the home, daycare or other community setting. The ITFS will demonstrate and teach the intervention strategies to caregivers. Example goals could encompass increasing word comprehension, using suggested strategies to facilitate or enhance oral motor development for making sounds and words, or implement behavioral strategies to improve communication.

Social/Emotional Skills – This refers to interpersonal relationship abilities. This includes interactions and relationships with parent(s) and caregivers, other family members, adults and peers, as well as behavioral characteristics, e.g., passive, active, curious, calm, anxious and irritable.

The ITFS, in consultation with the IFSP team, will work with caregivers on planning and developing individualized intervention strategies for the child to extend appropriate behaviors and interactions into everyday activities in the home, daycare or other community setting. The ITFS will demonstrate and teach the intervention strategies to caregivers as well as provide emotional support in coping with a difficult child. Example goals could encompass helping caregivers understand the child's behaviors and how to respond, development of strategies to set limits and manage the child's problems, development of strategies to help organize behaviors before they become uncontrollable while providing opportunities for normal active exploration.

Adaptive Development – This refers to the ability to function independently within the environment and the child’s competency with daily living activities such as sucking, eating, dressing, playing, etc., as appropriate for the child’s age.

The ITFS, in consultation with the IFSP team, will work with caregivers on planning and developing individualized intervention strategies for the child to extend self help skills into everyday activities in the home, daycare or other community setting. The ITFS will demonstrate and teach the intervention strategies to caregiver and child in collaboration with healing arts professionals, when appropriate. Example goals could encompass increasing acceptance of different food textures, acceptance of and handling utensils for self feeding, using suggested strategies to develop or enhance oral motor development for proper sucking or chewing, develop strategies to stimulate independent play, introduce concepts and develop strategies for self care in play such as dressing, bathing, brushing teeth, and brushing hair.

2. Developmental Testing

Developmental Testing is generally used as a screening tool to identify children who should receive a more intensive diagnostic evaluation and assessment. This service is provided by an educational diagnostician, psychologist, Certified Infant-Toddler Specialist, other clinical staff who meets the qualifications of an educational diagnostician, or other clinical staff who holds typically a Master’s Degree and has demonstrated competence in developmental testing to the satisfaction of the CDSA. This service is not for education purposes but to determine if there is risk for or determined developmental delay for referral to health related services such as Occupational Therapy, Physical Therapy, Speech Therapy, etc.

In the service delivery process, the role of the CDSA is to share with families the listing of qualified providers for each of the IFSP services. Any willing provider who meets the provider criteria can enroll with the CDSA and DMA as a Medicaid provider. The family will make the choice of providers utilized for their needs, and the providers will bill Medicaid directly for the services they provide.

Staff of the CDSA, private or public providers providing services to Medicaid recipients through an agreement with the CDSA, must meet the following minimum requirements, as appropriate to the discipline:

- Infant, Toddler, and Specialist Family certification or a qualified individual working toward certification at the required rate. Services performed by the Infant, Toddler, and Family certified individual must be ordered by the physician or licensed practitioner of the healing arts. These services are authorized by a plan of care developed by professionals acting within the scope of their practice under state law. In addition the Infant, Toddler, Family certified individual must be working under the direction of a physician or supervised by a licensed practitioner of the healing arts.

- As defined in 42 CFR 440.110, a Speech Pathologist who has a valid license issued by the NC Board of Examiners for Speech and Language Pathologists and Audiologists and has a certificate of clinical competence from the American Speech and Hearing Association; has completed the equivalent educational requirements and work experience necessary for the certificate; or has completed the academic program and is acquiring supervised work experience to qualify for the certificate.
- As defined in 42 CFR 440.110, an Audiologist who has a valid license issued by the NC Board of Examiners for Speech and Language Pathologists and Audiologists.
- As defined in 42 CFR 440.110, an Occupational Therapist who is registered by the American Occupational Association; or a graduate of a program in occupational therapy approved by the Committee on Allied Health Education and Accreditation of the American Medical Association and engaged in the supplemental clinical experience required before registration by the American Occupational Therapy Association.
- As defined in 42 CFR 440.110, a qualified physical therapist, an individual who is a graduate of a program of physical therapy approved by the Committee on Allied Health Education and Accreditation of the American Medical Association and engaged in the supplemental clinical experience required before registration by the American Physical Therapy Association or its equivalent; and where applicable, licensed by the State.
- A Nutritionist/Dietitian registered with the American Dietetic Association's Commission on Dietetic Registration or licensed by the NC Board of Dietetics/Nutrition.
- A Pediatrician, or Physician's Assistant, in accordance with the scope of the NC Medical Practice Act, or a Nurse Practitioner within the scope of the Nurse Practice Act
- A Registered Nurse licensed in the State of North Carolina, in accordance with the NC Board of Nursing.
- A Licensed Family and Marriage Counselor as defined in Article 18C of the Marital and Family Therapy Certification Act.
- A Licensed Clinical Social Worker (LCSW) or a Licensed Clinical Social Worker-Provisional (LCSW-P), in accordance with the Ethical Guidelines of the Social Worker Act (NCGS 90B) and the NASW Code of Ethics.
- An Educational Diagnostician, with a master's degree in special education or related field, with at least six hours of coursework and two years of experience in educational/developmental testing, or a bachelor's degree in special education or related field, with at least six hours of coursework and three years of experience in educational/developmental testing.
- A psychologist licensed by the NC Psychology Board, in accordance with the NC Psychology Act.
- Any willing provider who meets the provider criteria can enroll with the CDSA and DMA as a Medicaid provider.

5. Physicians' Services

All medical services performed must be medically necessary and may not be experimental in nature. Medical necessity is determined by generally accepted North Carolina community practice standards as verified by independent Medicaid consultants.

- a. Routine physician examinations and screening tests are covered for adults and EPSDT recipients, which include adults and children in nursing facilities.
- b. Experimental – Medical care that is investigatory or an unproven procedure or treatment regimen that does not meet generally accepted standards of medical practice in North Carolina.

In evaluating whether a particular service is or is not experimental the agency will consider safety, effectiveness and common acceptance as verified through 1) scientifically validated clinical studies 2) medical literature research and 3) qualified medical experts.

- c. Eye refractions are limited in frequency based upon State Medicaid Visual Services Policy, available on the Division's website located at www.dhhs.state.nc.us/dma/mp/mpindex.htm. Additional eye refractions may be authorized by the State Medicaid Agency, based on medical necessity.
- d. Injections are excluded when oral drugs may be used in lieu of injections.
- e. Therapeutic abortions are covered only in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by physician, place the woman in danger of death unless an abortion is performed; therapeutic abortions are also covered in cases of rape or incest.

6.a. Podiatrists' Services

- (1) Routine foot care is excluded.
- (2) Office visits (encounters) to one or a combination of physicians, clinics, hospital outpatient settings, chiropractors, podiatrists, and optometrists are limited to twenty-four (24) per recipient per State fiscal year. Additional visits in excess of the twenty-four (24) visit limit may be authorized by the State agency in emergency situations where the life of the patient would be threatened without such additional care. This limitation does not apply to EPSDT eligible children.

6.b. Optometrists' Services

- (1) Refractions are limited to one per year for recipients ages 24 and under; and one in two years for recipients ages 25 and over. This limitation was developed on the advice of professional medical consultants and was based on general medical practice.
- (2) Office visits (encounters) to one or a combination of physicians, clinics, hospital outpatient settings, chiropractors, podiatrists, and optometrists are limited to twenty-four (24) per recipient per State fiscal year.

Additional visits in excess of the twenty-four (24) visit limit may be authorized by the State agency in emergency situations where the life of the patient would be threatened without such additional care. This limitation does not apply to EPSDT eligible children.

6.c. Chiropractors' Services

- (1) Chiropractic services are limited to manual manipulation of the spine to correct subluxation which has resulted in a neuromusculoskeletal condition for which manipulation is appropriate. Conditions treated must be demonstrated to exist by x-ray taken within 6 months.
- (2) Office visits (encounters) to one or a combination of physicians, clinics, hospital outpatient settings, chiropractors, podiatrists, and optometrists are limited to twenty-four (24) per recipient per State fiscal year. Additional visits in excess of the twenty-four (24) visit limit may be authorized by the State agency in emergency situations where the life of the patient would be threatened without such additional care. This limitation does not apply to EPSDT eligible children.

6.d. Other practitioners' services

- (1) Limitations for nursing practitioner services are described in Appendix 5 to Attachment 3.1-A.
- (2) Licensed psychologists, licensed clinical social workers, licensed nurse practitioners certified in child and adolescent psychiatry and licensed clinical nurse specialists certified in child and adolescent psychiatry can provide psychotherapeutic assessment and treatment services to EPSDT eligible children with a referral from the Carolina ACCESS primary care provider or the area mental health program. Prior approval shall be required for each psychiatric hospital outpatient visit after the 26th visit for recipients under age 21.

7. Home Health

Home health services are provided by Medicare certified Home Health Agencies under a plan of care authorized by the patient's physician. Covered home health services include nursing services, services of home health aides, speech therapy, physical therapy, occupational therapy and medical supplies.

a. Intermittent or Part-Time Nursing Services Furnished by a Medicare certified Home Health Agency.

- (1) Care which is furnished only to assist the patient in meeting personal care needs is not covered.
- (2) Intermittent or part-time nursing service by a registered nurse when no home health agency exists in the area is limited to a registered nurse employed by or under contractual arrangement with a local health department.

6.d. **I. Other Practitioners' Services**

A. Criteria For Medicaid Coverage Of Nurse Practitioner Services

Nurse practitioner services means that the services are:

- 1) provided in accordance with the scope of practice as defined by the State Board of Medical Examiners and Board of Nursing;
- 2) performed by nurse practitioners who are duly licensed to practice nursing and are approved by the State Board of Medical Examiners and Board of Nursing as “nurse practitioners”; and
- 3) performed under the supervision of a physician licensed in the State of practice.

B. Coverage Limitations For Nurse Practitioner Services

Medical services must be performed in accordance with the nurse practitioners scope of practice and signed protocols, as follows:

- 1) By Nurse Practitioners in an independent practice (i.e. not in the employ of a practitioner, clinic or other service provider for the provision of Nurse Practitioner services).
- 2) For DMA approved procedures developed for use by Nurse Practitioners.
- 3) Subject to the same coverage limitations as those in effect for Physicians.

6.d. **I.** Other Practitioners' Services (continued)

- C. For Medicaid eligible adults, services may be provided by licensed psychologists, licensed clinical social workers, clinical nurse specialists (psychiatric mental health advanced practice), and nurse practitioners (psychiatric mental health advanced practice), licensed psychological associates, licensed professional counselors, and licensed marriage and family therapists. Medicaid eligible adults may be self referred. Prior approvals shall be required for each psychiatric outpatient visit after the eighth visit for recipients age 21 years and over.

b. Home Health Aide Services

The home health aide provides assistance to maintain health and to facilitate treatment of the illness or injury, under the supervision of a registered nurse according to North Carolina General Statute Chapter 90.

A terminally ill beneficiary who elects hospice care waives Medicaid coverage of services by a home health aide under home health services.

c. Medical supplies, equipment, and appliances suitable for use in the home.

(i) Medical Supplies

Medical supplies are covered when medically necessary, suitable for use in the home, and prescribed by a practitioner licensed according to North Carolina General Statute Chapter 90 under an approved plan of care and are limited to those items in the home that are medically necessary. These items will be covered when furnished by a Medicare Certified Home Health Agency, ME supplier (for supplies related to ME), PDN provider when providing PDN services (for supplies needed by a Division of Medical Assistance approved PDN patient), or local health department when such health department is providing intermittent or part-time nursing services to the patient as provided in 7.a. above.

(ii) Medical Equipment

Medically necessary medical equipment (ME) and associated supplies are covered by the Medicaid program when prescribed by a licensed healthcare practitioner and supplied by a qualified ME provider. Prior approval must be obtained from the Division of Medical Assistance, or its designated agent.

To be a qualified provider, an entity must possess a state business license and a Board of Pharmacy permit, and be certified to participate in Medicare as a ME supplier, or be a Medicaid enrolled home health agency, a state agency, a local health department, a local lead agency for the Community Alternatives Program (CAP) for disabled adults, or for the mentally retarded or developmentally disabled, or a local lead agency that provides case management for the Community Alternative Program for children.

Payment for medical equipment is limited to the official, approved ME list established by the Division of Medical Assistance. Additions, deletions or revisions to the ME list are approved by the Director of the Division of Medical Assistance upon recommendation of DMA staff. Only items determined to be medically necessary, effective and efficient are covered.

(iii) Home Infusion Therapy

Self-administered Home Infusion Therapy (HIT) is covered when it is medically necessary and provided through an enrolled HIT agency as prescribed by a physician. "Self-administered" means that the patient and/or an unpaid primary caregiver is capable, able, and willing to administer the therapy following teaching and with monitoring. The following therapies are included in this coverage when self-administered:

- a. Total parenteral nutrition
- b. Enteral nutrition
- c. Intravenous chemotherapy
- d. Intravenous antibiotic therapy
- e. Pain management therapy, including subcutaneous, epidural, intrathecal, and intravenous pain management therapy
- f. Low dose subcutaneous tocolytic therapy

An agency must be a home care agency licensed in North Carolina for the provision of infusion nursing services to qualify for enrollment as a Home Infusion Therapy Provider.

In addition to enrolled HIT providers, agencies enrolled to provide durable medical equipment may provide the supplies, equipment, and nutrient solutions/formulae for enteral infusion therapy.

SECTION 8: Private Duty Nursing Services

Medically necessary private duty nursing (PDN) services are provided when prescribed by a physician and prior approved by the Division of Medical Assistance or its designee.

Residents who are in domiciliary care facilities (such as rest homes, group homes, family care homes, and similar settings) are not eligible for this service. This exclusion does not violate comparability requirements as domiciliary care residents do not have the medical necessity for continuous nursing care. According to State regulations for domiciliary care, people are not to be admitted for professional nursing care under continuous medical supervision and residents who develop a need for such care are to be placed elsewhere. In addition, recipients in hospitals, nursing facilities, intermediate care facilities for the mentally retarded, rehabilitation centers, and other institutional settings are not eligible for this service. PDN services are not covered while an individual is being observed or treated in a hospital emergency room or similar environment.

This service is only approvable based on the need for PDN services in the patient's private residence. An individual with a medical condition that necessitates this service normally is unable to leave the home without being accompanied by a licensed nurse and leaving the home requires considerable and taxing effort. An individual may utilize the approved hours of coverage outside of his/her residence during those hours when the individual's normal life activities take the patient out of the home. The need for nursing care to participate in activities outside of the home is not a basis for authorizing PDN services or expanding the hours needed for PDN services.

Medicaid will not reimburse for Personal Care Services, Skilled Nursing Visits, or Home Health Aide Services provided during the same hours of the day as PDN services.

Medicaid Payments for PDN are made only to agencies enrolled with the Division of Medical Assistance as providers for the service. An enrolled provider must be a State licensed home care agency within North Carolina that is approved in its license to provide nursing services within the State.

A member of the patient's immediate family (spouse, child, parent, grandparent, grandchild, or sibling, including corresponding step and in-law relationship) may not be employed by the provider agency to provide PDN services reimbursed by Medicaid.

9. Clinic Services

All medical services performed must be medically necessary and may not be experimental in nature. Medical necessity is determined by generally accepted North Carolina community practice standards as verified by independent Medicaid consultants.

- a. Only service furnished by or under the direction of a physician or dentist are covered.
- b. Clinic services for which physicians or dentists file directly for payment are not covered.
- c. Services specifically covered under other Medicaid programs, e.g., Family Planning or EPSDT, are not reimbursable under the clinic program.
- d. Office visits (encounters) to one or a combination of physicians, clinics, hospital outpatient settings, chiropractors, podiatrists, and optometrists are limited to twenty-four (24) per recipient per State fiscal year. Additional visits in excess of the twenty-four (24) visit limit may be authorized by the State agency in emergency situations where the life of the patient would be threatened without such additional care. This limitation does not apply to EPSDT eligible children.

10. Dental Services

All dental services performed must be medically necessary and may not be experimental in nature. Medical necessity is determined by generally accepted North Carolina community practice standards as verified by independent Medicaid consultants.

- a. Routine dental examinations and screening tests are covered for adults and EPSDT recipients, which include adults and children in nursing facilities.
- b. Experimental – Dental care that is investigatory or an unproven procedure or treatment regimen that does not meet generally accepted standards of medical practice in North Carolina.

In evaluating whether a particular service is or is not experimental the agency will consider safety, effectiveness and common acceptance as verified through 1) scientifically validated clinical studies 2) dental literature research and 3) qualified dental experts.

- c. The services requiring prior approval are: complete dentures, partial dentures, complete and partial denture relines, orthodontic services, periodontal services, elective root canal therapy, and complex or extensive oral maxillo-facial surgical procedures. Emergency services are exempt from prior approval. The Division of Medical Assistance will have the responsibility of prior authorization of dental services.
- d. Endodontic treatment is covered for anterior teeth only.
- e. Experimental appliances are non-covered services.
- f. Payment for full mouth x-ray series is allowed only once every five (5) years.
- g. Replacement of complete or partial dentures may be made once every ten years. Replacement after the expiration of fewer than ten years may be made with prior approval if failure to replace the dentures will cause an extreme medical problem or irreparable harm. Initial reline of dentures may only be made if six months have elapsed since receipt of dentures. Subsequent relines are allowed only at five year intervals; if failure to reline in fewer than five years will cause an extreme medical problem or irreparable harm, relines may be made with prior approval. Standard procedures and materials shall be used for full and partial dentures.
- h. The state assures that EPSDT eligible clients have access to 1905(A) services not specifically listed in the state plan when they are medically necessary.

12.a. Prescribed Drugs

- (1) Limited to legend drugs, Insulin and selected over the counter (OTC) drugs designated per the North Carolina Division of Medical Assistance policy on Over the Counter Medications. Prior authorization is required for certain high-cost drugs which are subject to over-utilization or abuse.
- (2) For Non MAC drugs a prescription designated by a brand or trade name for which one or more equivalent drugs are available shall be considered to be an order for the drug by its generic name, except when the prescriber personally indicated in writing or in his own handwriting on the prescription order "DISPENSE AS WRITTEN". For MAC drugs the physician must write in his own handwriting on the face of the prescription "brand necessary", "dispense as written", or words of similar meaning.
- (3) Prescription drugs will be limited to six (6) per month per recipient including refills. Additional prescription drugs in excess of the six (6) per recipient per month limit may be authorized by the State agency in emergency situations when the life of the patient would be threatened without such additional services. This limitation does not apply to EPSDT eligible children.
- (4) Drugs for which Medical Assistance reimbursement is available are limited to the following:

Covered outpatient drugs of any manufacturer which has entered into and complies with an agreement under Section 1927(a) of the Act which are prescribed for a medically accepted indication. In addition, prior authorization must be obtained from the Medicaid agency or its authorized agent for any drug on the prior authorization list before Medicaid reimbursement is available. The state provides for response by telephone or other telecommunication device within 24 hours of a request for prior authorization. The state also provides for the dispensing of at least a 72-hour supply of a covered outpatient prescription drug in an emergency situation.

As provided by Section 1927(d) of the Act, certain outpatient drugs may be excluded from coverage. Those exclusions are for cosmetic purposes—Rogaine; Retin-A.

All other excludable drugs are covered.

Effective January 1, 1991 Medicaid will cover only drugs of participating manufacturers except 1-A drugs, where state process for approval must be described. (Because of extenuating circumstances waiver, state may cover non-participating manufacturers' drugs for claims with date of service through March 31, 1991.)

A formulary or other restrictions must permit coverage of participating manufacturers' drugs.

The state will comply with the reporting requirements for state utilization information and on restrictions to coverage.

If state has "existing" agreements, these will operate in conformance with law, and for new agreements, require HCFA approval. State must also agree to report rebates from separate agreements.

State must allow manufacturer to audit utilization data.

The unit rebate amount is confidential and cannot be disclosed for purposes other than rebate invoicing and verification.

Prior authorization programs must provide for a 24 hour turnaround on prior authorization from receipt of request and at least 72 hours supply in emergency situations (effective July 1, 1991).

States must cover new drugs of participating manufactures (except excludable/restrictable drugs) for 6 months after FDA approval and upon notification by the manufacturer of a new drug. The state may put the drug through its formulary but it cannot prior authorize the new drugs and, consistent with the second item above, it must cover drug (again with the exception of excludable/restrictable drugs). The state plan must list the classes chosen for exclusion/restriction or if less than the full class, list the drugs within the class chosen for exclusion/restriction.

The state may not reduce its limits on covered outpatient drugs or dispensing fees effective January 1, 1991 unless it was out of compliance with Federal requirements on November 5, 1990.

State Plan Under Title XIX of the Social Security Act
Medical Assistance Program
State: NORTH CAROLINA

Medicaid Program: Requirements Relating to Covered Outpatient Drugs for the Categorically
Needy

12.a. PRESCRIBED DRUGS

Citation (s)	Provision (s)
USC 1935(d)(1)	Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

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State Plan Under Title XIX of the Social Security Act
Medical Assistance Program
State: NORTH CAROLINA

Medicaid Program: Requirements Relating to Covered Outpatient Drugs for the Categorically
Needy

12.a. PRESCRIBED DRUGS *continued*

Citation (s)	Provision (s)
USC 1927(d)(2) and 1935(d)(2)	<p>The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit – Part D.</p> <p>(1) The following excluded drugs are covered:</p> <ul style="list-style-type: none"><input checked="" type="checkbox"/> (a) Agents when used for the symptomatic relief of cough and colds All legend products that contain expectorants or cough suppressants. Examples are: expectorant/antitussive combination, antihistamine/decongestant/antitussive combination, antihistamine/decongestant/expectorant combination, antihistamine/decongestant/expectorant/antitussive combination, antihistamine/expectorant combination, antihistamine/antitussive, antitussive/decongestant/analgesic/expectorant, and antitussive/decongestant/analgesic<input checked="" type="checkbox"/> (b) All legend vitamins and mineral products, except prenatal vitamins and fluoride<input checked="" type="checkbox"/> (c) Non-prescription drugs North Carolina (NC) will only cover selected rebateable over the counter (OTC) products when not covered by the prescription drug plans (PDPs). Examples of OTC drugs covered are: Insulin products, non-sedating antihistamines e.g. Loratadine OTC and Claritin OTC, proton pump inhibitors e.g. Prilosec OTC.

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State Plan Under Title XIX of the Social Security Act
Medical Assistance Program
State: NORTH CAROLINA

Medicaid Program: Requirements Relating to Covered Outpatient Drugs for the Categorically
Needy

12.a. PRESCRIBED DRUGS *continued*

Citation (s)	Provision (s)
USC 1927(d)(2) and 1935(d)(2)	<p><input checked="" type="checkbox"/> (d) All Barbiturates</p> <p><input checked="" type="checkbox"/> (e) All Benzodiazepines</p> <p><input checked="" type="checkbox"/> (f) Agents when used to promote smoking cessation (non-duals only). NC will cover legend products the non-duals. NC will cover for the duals (when not covered by the PDPs) and non-duals selected rebateable OTC products. Some examples are: Nicoderm CQ, Nicotrol, Commit, and Nicorette Gum.</p> <p>(2) The following excluded drugs are not covered:</p> <p>(a) Agents when used for anorexia, weight loss, weight gain</p> <p>(b) Agents when used to promote fertility</p> <p>(c) Agents when used for cosmetic purposes or hair growth</p> <p>(d) Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee</p>

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12.b Dentures

- (1) Complete and partial dentures are allowed only in a ten (10) year period. Prior approval is required. Initial relines of dentures may be reimbursed only if six (6) months have elapsed since receipt of dentures. Subsequent relines are allowed only at five (5) year intervals.

12.c Medically necessary orthotic and prosthetic devices are covered by the Medicaid program when prescribed by a qualified licensed healthcare practitioner and supplied by a qualified provider. Only items determined to be medically necessary, effective and efficient are covered. Items which require prior approval are indicated by an asterisk beside the HCPCS code on the Orthotic and Prosthetic Fee Schedule. This fee schedule is located at www.dhhs.state.nc.us/dma/fee/fee.htm.

A qualified orthotic and prosthetic device provider must be approved by the Division of Medical Assistance. The provider requirements are published in Medicaid Clinical Coverage Policies on the NC Division of Medical Assistance website (www.dhhs.state.nc.us/dma/dme/5B.pdf).

Prior approval is required for certain orthotic and prosthetic devices. The decision to require prior approval for a specific procedure, product or service and the requirements that must be met for prior approval are based on evaluation of the factors such as: utilization; efficacy; safety; potential risk to patients; potential for misuse or abuse; high cost; the availability of more cost effective or equivalent procedures, products and services; and legislative mandate. High cost is cost in comparison to other covered items and related maintenance. Such a designation would usually be arrived at by a team of DMA staff from fiscal, programmatic and Program Integrity areas. Whether the recipient gets the item or not is dependent on the rationale for medical need and the unavailability of another less costly item that would adequately address the need. Session Law 2004-124 states "medically necessary prosthetics and orthotics are subject to prior approval and utilization review." Specific prior approval requirements are published in Medicaid Clinical Coverage Policies on the NC Division of Medical Assistance website (www.dhhs.state.nc.us/dma/dme/5B.pdf).

**EPDST Orthotic and Prosthetic Information is located at: Attachment 3.1-A.1, Page 7b.*

12.d Eyeglasses

- (1) All visual aids require prior approval.
- (2) No eyeglass frames other than frames made of zylonite, metal or combination zylonite and metal shall be covered.
- (3) Eyeglass repair or replacement, or any other service costing five dollars \$5.00 or less, shall not be covered.

13. Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services
These services are available to categorically needy and medically needy recipients. They are provided by staff employed by programs/agencies who are directly enrolled by the Medicaid Agency to perform a specific service or individually licensed practitioners who have been directly enrolled by the Medicaid Agency. Staff of the agency providing services will also meet requirements set forth in Federal regulations or the requirements for one of the three categories described on pages 15a.14 and 15a.15; and in the North Carolina Practice Act. Services include the following:

A. Medically necessary diagnostic evaluations or assessments (Diagnostic Assessment) identify the existence, nature and extent of illness. The services may include a systematic appraisal of mental, psychological, physical, behavioral, functional, social, economic and/or intellectual limitations and resources of the individual in order to determine the nature and extent of illness. This information will be used in the formulation of an individualized person centered plan for the recipient. 42 CFR 430.130(a)

B. Other medically necessary diagnostic, screening, treatment, preventive and rehabilitative (ODSPR) services for the mentally ill, developmentally disabled and substance abusers are covered benefits when medically necessary. Screening services means the use of standardized tests given under medical direction. Diagnostic, preventive, or rehabilitative services must be ordered by a physician, licensed psychologist, physician's assistant or nurse practitioner practicing within the scope of his/her practice according to Chapter 90 of the North Carolina General Statutes. 42 CFR 430.130(d)

Covered services are provided to recipients in their residence or in a community setting other than in a public institution (IMD), jail or detention facility.

The following services will be covered when a determination is made that the service will meet specific behavioral health needs of the recipient. Specific services must ameliorate diagnosable conditions or prevent the anticipated deterioration of the patient's condition. Services provided to family members of the recipient must be related to the recipient's mental health/substance abuse disability.

Covered services for adults include: Evaluation/Assessments/Psycho-therapy/Behavioral Health Counseling, Diagnostic Assessment, Counseling, Community Supports Adults, Psychosocial Rehabilitation, Partial Hospital, Mobile Crisis Management, Community Support Team Adults, Assertive Community Treatment Team, Professional Treatment Services in Facility-Based Crisis Programs, Opioid Treatment, Substance Abuse Intensive Outpatient, Substance Abuse Comprehensive Outpatient Treatment, Substance Abuse Non-Medical Community Residential Treatment (excluding room and board), Substance Abuse Medically Monitored Residential Treatment (excluding room and board), Ambulatory Detoxification, Non-Hospital Medical Detoxification, and Medically Monitored or Alcohol Drug Addiction Treatment Center Detoxification/Crisis Stabilization.

13. C. Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services
Description of Services

(i) Evaluation/Assessments/ Psycho-therapy/Behavioral Health Counseling

For the complete description of the service, see Attachment 3.1-A.1 pages 15a.14 and 15a.15. (In accordance with 42 CFR 430.130)

(ii) Diagnostic Assessment

This is a clinical face to face evaluation of a recipient's mh/dd/sas condition that will establish a need for the enhanced benefit package of services. It is a team service and must include evaluations by either, a physician, physician assistant, nurse practitioner or licensed psychologist who can sign an order for services and a licensed or certified practitioner with expertise in mh/dd/sas as appropriate and consist of the following:

- a chronological general health and behavioral health history (includes both mental health and substance abuse) of the recipient's symptoms, treatment, treatment response and attitudes about treatment over time, emphasizing factors that have contributed to or inhibited previous recovery efforts; biological, psychological, familial, social, developmental and environmental dimensions and identified strengths and weaknesses in each area;
- a description of the presenting problems, including source of distress, precipitating events, associated problems or symptoms, recent progressions, and current medications;
- a strengths/problem summary which addresses risk of harm, functional status, co-morbidity, recovery environment, and treatment and recovery history;
- diagnoses on all five (5) axes of DSM-IV;
- evidence of an interdisciplinary team progress note that documents the team's review and discussion of the assessment;
- a recommendation regarding target population eligibility; and
- evidence of recipient participation including families, or when applicable, guardians or other caregivers.

Documentation must include the following elements:

- a chronological general health and behavioral health history (includes both mental health and substance abuse) of the recipient's symptoms, treatment, treatment response and attitudes about treatment over time, emphasizing factors that have contributed to or inhibited previous recovery efforts; biological, psychological, familial, social, developmental and environmental dimensions and identified strengths and weaknesses in each area;
- a description of the presenting problems, including source of distress, precipitating events, associated problems or symptoms, recent progressions, and current medications;
- strengths/problem summary which addresses risk of harm, functional status, co-morbidity, recovery environment, and treatment and recovery history;
- diagnoses on all five (5) axes of DSM-IV;
- evidence of an interdisciplinary team progress note that documents the team's review and discussion of the assessment;
- a recommendation regarding target population eligibility; and
- evidence of recipient participation including families, or when applicable, guardians or other caregivers.

All other services in this section are covered in 42 CFR 430.130(d).

13. C. Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services (continued)
Description of Services

(iii) Community Support - (adults) (CS)

This service is available to adults and will become the “clinical home” for mental health services (similar to medical home for medical services) of the adult. The interventions which are carried out by a Qualified Professional, a Certified Clinical Supervisor or a Certified Clinical Addictions Specialist may include:

- Coordination and Oversight of Initial and Ongoing Assessment Activities,
- Initial Developmental and Ongoing revision of PCP,
- Monitoring Implementation of PCP; and
- Other case management functions of linking and referring.

The interventions carried out by an associate professional or a paraprofessional may include:

- training of the care giver,
- preventive, and therapeutic activities that will assist with skill building,
- relational skills,
- symptom monitoring,
- therapeutic mentoring; and
- behavior and Anger management.

The service must be ordered by a physician, licensed psychologists, physician’s assistant or nurse practitioner. The providers of this service will also serve as a “first responder” in a crisis situation. The service will be provided as an agency based service with qualified professionals, paraprofessionals and associate, who must have 20 hours of training specific to the requirements of the service definition within the first 90 days of employment. Specific clinical criteria (medical necessity criteria for initiation and continuation) are contained in the definition. Documentation must include: a service note that includes the recipient’s name, Medicaid identification number, date of service, purpose of contact, describes the provider’s interventions, includes the time spent performing the interventions, effectiveness of the intervention, and the signature of the staff providing the service. There are systems limitations indicated to prevent this service from being provided while an adult is an inpatient or receiving residential treatment, or an intensive substance abuse service. Prior approval will be required via the statewide UR vendor or by an approved LME contracted with the Medicaid Agency and meeting the same standards and requirements as the statewide vendor. This initial prior approval process will ensure that the level of the service is appropriate and concurrent reviews will determine the ongoing medical necessity for the service or the need to move up or down the continuum of services to another level of care.

13. C. Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services (continued)
Description of Services (42 CFR 30.130(a))

(iv) Psychosocial Rehabilitation

This service provides skills development, educational and prevocational activities:

- Community living such as house keeping, shopping, cooking, use of transportation facilities, money management,
 - Personal care such as health care, medication self management, grooming,
 - Social relationships,
 - Educational activities which include assisting client in securing needed educational services such as adult basic education and special interest courses; and
 - Prevocational activities which focus on development of positive work habits and participation on activities that increase participant's self worth, purpose and confidence.
- These activities are not to be job specific training.

It is available for a period of 5 or more hours per day. The interventions must be included in a treatment plan and may be any of the following: behavioral interventions/management, social and other skill development, adaptive skill training, enhancement of communication and problem solving skills, anger management, family support, medication monitoring, monitoring of changes in psychiatric symptoms/or functioning and positive reinforcement. It is provided in a licensed facility with staff to recipient ratio of 1:8. This service is provided to outpatients by a mental health organization that meets State licensure requirements, and providers of the services will meet the appropriate Federal requirements or the State requirements as described on pages 15a.14 and 15a.15. Documentation must include: a daily full service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, describes the provider's interventions, includes the time spent performing the interventions, effectiveness of the intervention, and the signature of the staff providing the service. This service must be ordered by an MD, NP, PA or PhD psychologist. Prior approval will be required via the statewide UR vendor or by an approved LME contracted with the Medicaid Agency and meeting the same standards and requirements as the statewide vendor. This initial prior approval process will ensure that the level of the service is appropriate and concurrent reviews will determine the ongoing medical necessity for the service or the need to move up or down the continuum of services to another level of care.

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13. C. Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services (continued)
Description of Services (42 CFR 30.130(a))

(v) Partial Hospital (PH)

This is a short term service for acutely mentally ill adults which provides a broad range of intensive therapeutic approaches which may include:

- Individual/group therapies,
- Increase the individual's ability to relate to others,
- Community living skills/training,
- Coping skills,
- Medical services; and
- This is used as a step up to inpatient or a step down from inpatient.

Physician involvement is required. This service must be offered at a minimum of 4 hours per day, 5 days/week. Clinical criteria (medical necessity criteria for admission and continued stay) are embedded in the service definition. Documentation must include: a daily full service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, describes the provider's interventions, time spent performing the intervention, effectiveness of the intervention, and the signature of the staff providing the service. The service must be ordered by a physician, licensed psychologists, physician's assistant or nurse practitioner and prior approval will be required via the statewide UR vendor or by an approved LME contracted with the Medicaid Agency and meeting the same standards and requirements as the statewide vendor. This initial prior approval process will ensure that the level of the service is appropriate and concurrent reviews will determine the ongoing medical necessity for the service or the need to move up or down the continuum of services to another level of care.

13. C. Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services (continued)
Description of Services

(vi) Mobile Crisis Management

This involves all supports, services and treatments necessary to provide integrated crisis response, crisis stabilization interventions and crisis prevention activities. It is available 24/7/365 and provides immediate evaluation, triage and access to acute mh/dd/sas services, treatment, supports to effect symptom reduction, harm reduction and/or to safely transition persons in acute crisis to the appropriate environment for stabilization. It is provided by a team that includes a Qualified Professional who must be a nurse, a clinical social worker or psychologist. Teams include substance abuse professionals, and a psychiatrist must be available for face to face or telephone consults. Paraprofessionals with crisis management experience may also be included on the team but must work under the supervision of a professional. Experience with the appropriate disability group is required and 20 hours of crisis intervention training within the first 90 days of employment is necessary. The maximum length of the service is 24 hours per episode and prior authorization will be required via the statewide UR vendor or by an approved LME contracted with the Medicaid Agency and meeting the same standards and requirements as the statewide vendor after the first 8 hours for the remaining 16 hours. Documentation must include: a service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, describes the provider's interventions, includes the time spent performing the interventions, effectiveness of the intervention, and the signature of the staff providing the service.

NOTE: This has a limitation because the service requires stabilization or movement into an environment that can stabilize.

13. C. Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services (continued)
Description of Services

(vii) Community Support Team (CST) - (adults)

Services provided by this team consist of mental health and substance abuse services and supports necessary to assist adults in achieving rehabilitation and recovery goals. It assists individuals to gain access to necessary services; reduce psychiatric and addiction symptoms; and develop optimal community living skills. The services include assistance and support to individuals in crisis situation; service coordination; psycho education and support for individuals and their families; independent living skills; development of symptom monitoring and management skills, monitoring medications and self-medication.

- Assist individuals to gain access to necessary services to reduce psychiatric and addiction symptoms,
 - Assistance and support for individuals in crisis situations,
 - Service coordination,
 - Psycho-education,
 - Individual restorative interventions for development of interpersonal, community coping and independent living skills; and
 - Monitoring medications and self medication.

Documentation must include: a service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, describes the provider's interventions, includes the time spent performing the interventions, effectiveness of the intervention, and the signature of the staff providing the service.

The CST provider assumes the role of advocate, broker, coordinator and monitor of the service delivery system on the behalf of the recipient. The service must be ordered and prior approval will be required. A CST team will be comprised of 3 staff persons one of which is the team leader and must be a QP. The other two may be a QP, AP or a paraprofessional. The team maintains a consumer to practitioner ratio of no more than fifteen consumers per staff person. All staff providing this service must have a minimum of one year documented experience with the adult population and completion of a minimum of twenty hours of crisis management and community support team service definition required within the first 90 days of hire. Clinical criteria are imbedded in the definition as well as service limitations to prevent duplication of services. It must be ordered by either, a physician, physician assistant, nurse practitioner or licensed psychologist. Prior approval will be required via the statewide UR vendor or by an approved LME contracted with the Medicaid Agency and meeting the same standards and requirements as the statewide vendor. This initial prior approval process will ensure that the level of the service is appropriate and concurrent reviews will determine the ongoing medical necessity for the service or the need to move up or down the continuum of services to another level of care.

NOTE: This service is used as an intervention to avoid need for a higher level of care or of as a step down from a higher level of care. It is an ACTT "lite" service.

13. C. Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services (continued)
Description of Services

(viii) Assertive Community Treatment Team (ACTT)

This existing service is provided by a multidisciplinary team to recipients when it has been determined that the mental health/substance abuse needs are so pervasive and/or unpredictable that they cannot be met by a combination of other services. The team provides evaluations (an assessment to determine the extent of the problems), outpatient treatment, case management, and community based services (described below) for individuals with mental health and substance abuse diagnoses. These are all bundled into therapeutic interventions and include crisis response as the first responder.

- Service Co-ordination,
- Crisis assessment and intervention,
- Symptom assessment and management,
- Individual counseling and psychotherapy,
- Medication monitoring, administration and documentation,
- Substance abuse treatment,
- Support or direct assistance to ensure the individuals obtain the basic necessities of daily life including activities of daily living, social, interpersonal relationships and leisure time activities; and
- Support and consultation to families and other major supports.

It is available 24/7/365, in any location except jails, detention centers, clinic settings and hospital inpatient settings. Recipient to staff ratio is 10-1 with a maximum of 12-1. Documentation must include: a service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, describes the provider's interventions, includes the time spent performing the interventions, effectiveness of the intervention, and the signature of the staff providing the service. Minimum staff per team is a Qualified Professional, RN, paraprofessional staff, certified peer specialist, a physician full time or part time for a minimum of 16 hours per week for every 50 clients. The team will provide an average of three contacts per week for all individuals. (This is billed per diem; the claims system is set so it will not reimburse for more than 4 in 1 month.). The service is intended to provide support and guidance in all functional domains to enhance the recipient's ability to remain in the community. No other periodic mental health services can be billed in conjunction with this service. This service must be ordered by an MD, NP, PA or PhD psychologist. Evidenced based best practices for this service have been incorporated into the service definitions associated with SPA 05-005. Clinical criteria are also included in the definition. Prior approval will be required via the statewide UR vendor or by an approved LME contracted with the Medicaid Agency and meeting the same standards and requirements as the statewide vendor. This initial prior approval process will ensure that the level of the service is appropriate and concurrent reviews will determine the ongoing medical necessity for the service or the need to move up or down the continuum of services to another level of care.

13. C. Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services (continued)
Description of Services

(ix) Professional Treatment Services in Facility-Based Crisis Programs (FBC)

This existing service serves as an alternative to hospitalization for recipients who have mental illness/substance abuse disorder. It is a 24 hour residential facility that provides support and crisis services in a community setting. The services are provided under the supervision of a physician with interventions implemented under the physician direction. The purpose is to implement intensive treatment, behavioral management, interventions or detoxification protocols, to stabilize the immediate problems and to ensure the safety of the individual.

- Evaluation (assesses condition),
- Intensive treatment,
- Stabilization (behavioral management),
- Monitoring response to interventions; and
- Provide linkage for other services.

It is offered 7 days/week and must be provided in a licensed facility. At no time will the staff to recipient ratio be less the 1:6 for adult mental health recipients, 1:9 for substance abuse recipients. This is a short term service that does not exceed 15 days and cannot exceed a total of 30 days in a 12 month period. Documentation must include: a daily full service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, describes the provider's interventions, includes the time spent performing the interventions, effectiveness of the intervention, and the signature of the staff providing the service. Prior approval will be required via the statewide UR vendor or by an approved LME contracted with the Medicaid Agency and meeting the same standards and requirements as the statewide vendor at the end of 7 days, if additional days are needed. This initial prior approval process will ensure that the level of the service is appropriate and concurrent reviews will determine the ongoing medical necessity for the service or the need to move up or down the continuum of services to another level of care.

This service must be provided in a facility with 16 beds or less. Medicaid reimburses only treatment costs.

13. C. Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services (continued)
Description of Services

(x) Opioid Treatment

This existing service is provided through the LMEs for the treatment of Opioid addiction in conjunction with the provision of rehabilitation and medical services. It is provided only for treatment and/or maintenance. The program must be licensed and must meet the Federal Guidelines for this program. Providers will be direct enrolled. It is provided by an RN, LPN, Pharmacist or MD. This service must be ordered by an MD, NP, PA or PhD psychologist. Prior approval will be required via the statewide UR vendor or by an approved LME contracted with the Medicaid Agency and meeting the same standards and requirements as the statewide vendor. This initial prior approval process will ensure that the level of the service is appropriate and concurrent reviews will determine the ongoing medical necessity for the service or the need to move up or down the continuum of services to another level of care.

(xi) Substance Abuse Intensive Outpatient (SAIOP)

This service provides motivational enhancement and engagement, therapies for recovery, random alcohol/ drug testing, and strategies for relapse prevention, including community and/or other strategies for relapse preventions. These therapies include:

- Individual counseling and support,
- Group counseling and support,
- Family counseling and support,
- Biochemical assays to identify recent drug use (e.g. urine drug screens),
- Strategies for relapse prevention: community and social support systems in treatment,
- Crisis contingency planning,
- Disease management; and
- Treatment support activities that have been adapted or specifically designed for persons with physical disabilities, persons with co-occurring disorders of mental illness and substance abuse/dependence or mental retardation/developmental disabilities and substance abuse/dependence.

SAIOP must be available for a minimum of 3 hours per day. It is operated out of a licensed substance abuse facility but can be provided in a variety of settings. The maximum face to face ratio is an average of not more than 12 recipients to 1 direct service staff based on average daily attendance. This service can only be provided by qualified substance abuse professional staff with the following licenses or certifications: Licensed Psychological Associates, Licensed Professional Counselors, Licensed Clinical Social Workers, Certified Clinical Supervisors, Certified Substance Abuse Counselors, and Licensed Clinical Addiction Specialists; or a QP, AP or paraprofessional. Documentation must include: a daily full service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, describes the provider's interventions, includes the time spent performing the interventions, effectiveness of the intervention, and the signature of the staff providing the service. This service must be ordered by an MD, NP, PA or PhD psychologist. Prior approval will be required via the statewide UR vendor or by an approved LME contracted with the Medicaid Agency and meeting the same standards and requirements as the statewide vendor. This initial prior approval process will ensure that the level of the service is appropriate and concurrent reviews will determine the ongoing medical necessity for the service or the need to move up or down the continuum of services to another level of care.

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13. C. Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services (continued)
Description of Services

(xii) Substance Abuse Comprehensive Outpatient Treatment (SACOT)

This periodic service is a time-limited, multifaceted service approach for adults who require structure and support to achieve and sustain recovery. It emphasizes reduction in use and abuse of substances and/or continued abstinence, the negative consequences of substance abuse, development of a support network necessary to support necessary life style changes, and the continued commitment to recovery. The individual components of the services include:

- Individual counseling and support,
- Group counseling and support,
- Family counseling and support,
- Biochemical assays to identify recent drug use (e.g. urine drug screens),
- Strategies for relapse prevention to include community and social support systems in treatment,
- Crisis contingency planning,
- Disease management; and
- Treatment support activities that have been adapted or specifically designed for persons with physical disabilities, pr persons with co-occurring disorders of mental illness and substance abuse/dependence or mental retardation/developmental disabilities and substance abuse/dependence.

This service must operate at least 20 hours per week and offer a minimum of 4 hours of scheduled services per day with availability of at least 5 days per week with no more than a 2 day lapse between services. Documentation must include: a daily full service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, describes the provider's interventions, includes the time spent performing the interventions, effectiveness of the intervention, and the signature of the staff providing the service. Staff must meet the requirements for CCS, LCAS and CSAC or a QP, AP or paraprofessional. Recipients must have ready access to psychiatric assessment and treatment services when warranted by the presence of symptoms indicating a co-occurring disorder. This service must be ordered by an MD, NP, PA or PhD psychologist. Prior approval will be required via the statewide UR vendor or by an approved LME contracted with the Medicaid Agency and meeting the same standards and requirements as the statewide vendor. This initial prior approval process will ensure that the level of the service is appropriate and concurrent reviews will determine the ongoing medical necessity for the service or the need to move up or down the continuum of services to another level of care.

13. C. Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services (continued)
Description of Services

(xiii) Substance Abuse Non-Medical Community Residential Treatment

This is a 24 hour residential recovery program professionally supervised that works intensively with adults. It is a licensed rehabilitation facility with 16 beds or less without medical nursing/ monitoring, with a planned program of professionally directed evaluation, care and treatment for the restoration of functioning for persons with an addictions disorder. Programs include assessment/referral, individual and group therapy, family recovery, recovery skills training, case management, disease management, symptoms monitoring, medication monitoring and self management of symptoms. Services in the person centered plan will be adapted to the client's developmental and cognitive level. Staff requirements are CCS, LCAS and CSAC; or a QP, AP or paraprofessional (staff definitions are included at the end of this document). Medical necessity is defined in the body of the definition and utilization review will be required. Documentation must include: a daily full service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, describes the provider's interventions, time spent performing the intervention, effectiveness of the intervention, and the signature of the staff providing the service. This service will not be billed on the same day as any other mh/dd/sas service. Medicaid will not pay room and board; will pay only the treatment component. This service must be ordered by an MD, NP, PA or PhD psychologist. Prior approval will be required via the statewide UR vendor or by an approved LME contracted with the Medicaid Agency and meeting the same standards and requirements as the statewide vendor. This initial prior approval process will ensure that the level of the service is appropriate and concurrent reviews will determine the ongoing medical necessity for the service or the need to move up or down the continuum of services to another level of care. This is a short term service that cannot be provided for more than 30 days in a 12 month period.

(xiv) Substance Abuse Medically Monitored Residential Treatment

This is a 24 hour non-hospital, medically monitored facility with 16 beds or less, with 24 hour medical/nursing monitoring where a planned program of professionally directed evaluation, care and treatment for the restoration of functioning for persons with alcohol and other drug problems/addictions occurs. This facility is not a detoxification facility but the focus is on treatment after detoxification has occurred.

- Non hospital rehabilitation facility,
- Assessments,
- Monitoring of patient's progress and medication administration,
- Treatment relating to restoration of functioning (sustained improvement in health and psychosocial functioning, reduction of psychiatric symptoms when present, and reduction in risk of relapse); and
- First responder for crisis intervention.

It is staffed by Certified Clinical Supervisor, Licensed Clinical Addiction Specialist and Certified Substance Abuse Counselor's, QPs, APs and paraprofessionals with training and expertise with this population. Documentation must include: a daily full service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, describes the provider's interventions, includes the time spent performing the interventions, effectiveness of the intervention, and the signature of the staff providing the service. This service must be ordered by an MD, NP, PA or PhD psychologist. Prior approval will be required via the statewide UR vendor or by an approved LME contracted with the Medicaid Agency and meeting the same standards and requirements as the statewide vendor. This initial prior approval process will ensure that the level of the service is appropriate and concurrent reviews will determine the ongoing medical necessity for the service or the need to move up or down the continuum of services to another level of care. This is a short term service that cannot be provided for more than 30 days in a 12 month period.

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13. C. Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services (continued)
Description of Services

(xv) Ambulatory Detoxification

Ambulatory detox is an organized service delivered by trained practitioners who provide medically supervised evaluations, detoxification and referral services in a licensed facility, according to a predetermined schedule. These services are provided in regularly scheduled sessions by a CCS, LCAS, QP or AP. A physician is available 24/7 to conduct an assessment within 24 hours of admission. A registered nurse is available to conduct a nursing assessment on admission and oversee the monitoring of patient's progress and medications. Documentation must include: a service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, describes the provider's interventions, time spent performing the intervention, effectiveness of the intervention, and the signature of the staff providing the service. This service must be ordered by an MD, NP, PA or PhD psychologist. Prior approval will be required via the statewide UR vendor or by an approved LME contracted with the Medicaid Agency and meeting the same standards and requirements as the statewide vendor. This initial prior approval process will ensure that the level of the service is appropriate and concurrent reviews will determine the ongoing medical necessity for the service or the need to move up or down the continuum of services to another level of care.

(xvi) Non-Hospital Medical Detoxification

Medically monitored detoxification is an organized service by medical and nursing professionals that provides for 24 hour medically supervised evaluations and withdrawal management in a licensed permanent facility affiliated with a hospital or in a freestanding facility of 16 beds or less. It is staffed by CCS, LCAS, CSAC, QP, AP and paraprofessionals. A physician is available 24 hours a day by telephone and conducts an assessment within 24 hours of admission. A registered nurse is available to conduct a nursing assessment on admission and oversee the monitoring of patient's progress and medications. Specifics of clinical criteria are included in the definition. The focus of this service is detoxification. Documentation must include: a daily full service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, describes the provider's interventions, includes the time spent performing the interventions, effectiveness of the intervention, and the signature of the staff providing the service. This service must be ordered by an MD, NP, PA or PhD psychologist. Prior approval will be required via the statewide UR vendor or by an approved LME contracted with the Medicaid Agency and meeting the same standards and requirements as the statewide vendor. This initial prior approval process will ensure that the level of the service is appropriate and concurrent reviews will determine the ongoing medical necessity for the service or the need to move up or down the continuum of services to another level of care. This is a short term service that cannot be provided for more than 30 days in a 12 month period.

13. C. Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services (continued)
Description of Services

(xvii) Medically Monitored or Alcohol Drug Addiction Treatment Center Detoxification
(ADATC)/Crisis Stabilization

This is an organized service delivered by medical and nursing personnel that provides 24 hour medically supervised evaluation and withdrawal management in a licensed permanent facility with 16 or less beds. Services are delivered under a defined set of physician approved policies and physician monitored procedures and clinical protocols. Recipients are often in crisis due to co-occurring severe substance-related mental disorders and are in need of short term intensive evaluation, treatment intervention or behavioral management to stabilize the acute or crisis situation.

- Medically supervised evaluation and withdrawal management,
- Intensive evaluation,
- Treatment interventions,
- Behavioral management to stabilize the acute or crisis situation; and
- Established protocols are established to transfer patients, with severe biomedical conditions who are in need of medical services beyond the capacity of the facility, to the appropriate level of care.

The service has restraint and seclusion capabilities. Recipients are carefully evaluated to ensure they do not need a different level of care. A registered nurse is available to conduct a nursing assessment on admission and oversee the monitoring of patient's progress and medications on an hourly basis. Appropriately licensed and credentialed staff is available to administer medications in accordance with physician's orders. Clinical criteria (medical necessity criteria for admission and continued stay) are imbedded in the definition. Documentation must include: a daily full service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, describes the provider's interventions, time spent performing the intervention, effectiveness of the intervention, and the signature of the staff providing the service. This service must be ordered by an MD, NP, PA or PhD psychologist. Prior approval will be required via the statewide UR vendor or by an approved LME contracted with the Medicaid Agency and meeting the same standards and requirements as the statewide vendor. This initial prior approval process will ensure that the level of the service is appropriate and concurrent reviews will determine the ongoing medical necessity for the service or the need to move up or down the continuum of services to another level of care. This is a short term service that cannot be provided for more than 30 days in a 12 month period.

13. E. Behavioral Health Rehabilitative Services (continued)

Provider Qualifications for Staff Employed by Agencies Enrolled with Medicaid

Providers will meet either the appropriate Federal regulations or the requirements for one of the three categories described on pages 15a.14 and 15a.15.

- i) Paraprofessional
“Paraprofessional” within the mental health and substance system means an individual who has a GED or high school diploma (or no GED or high school diploma if employed prior to November 1, 2001). Supervision shall be provided by a qualified professional or associate professional with the population served.
- ii) Associate Professional (AP)
“Associate Professional” within the mental health and substance abuse services system means an individual who is a:
 - graduate of college or university with a Masters degree in a human service field and less than one year of full time post-graduate mental health or substance abuse experience with the population served or a substance abuse professional with less than one year of full-time, post-graduate degree supervised experience in alcoholism and drug abuse counseling. Supervision shall be provided by a qualified professional with the population served until the individual meets one year of experience; or
 - graduate of college or university with a bachelor’s degree in a human service field with less than two years of full-time post-bachelor’s degree mental health or substance abuse experience with the population served, or a substance abuse professional with less than two years post bachelor’s degree accumulated supervised experience in alcoholism and drug abuse counseling. Supervision shall be provided by a qualified professional with the population served until the individual meets two years of experience; or
 - graduate of a college or university with a bachelor’s degree in a field other than human services with less than four years of full-time, post bachelor’s degree accumulated supervised experience in mental health or substance abuse with the population served. Supervision shall be provided by a qualified professional with the population served until the individual meets four years of experience; or
 - registered nurse who is licensed to practice in the State of North Carolina by the North Carolina Board of Nursing with less than four years of full-time accumulated experience in mental health or substance abuse with the population served. Supervision shall be provided by a qualified professional with the population served until the individual meets four years of experience.

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13. E. Behavioral Health Rehabilitative Services (continued)
Provider Qualifications for Staff Employed by Agencies Enrolled with Medicaid

- (iii) Qualified Professional (QP)
“Qualified Professional” within the mental health and substance abuse system means:
- an individual who holds a license, provisional license, certificate, registration or permit issued by the governing board regulating a human service profession, except a registered nurse who is licensed to practice in the State of North Carolina by the North Carolina Board of Nursing, who also has four years of full-time accumulated experience in mh/sa with the population served; or
 - a graduate of a college or university with a Masters degree in a human service field and one year of full-time, post-graduate degree experience with the population served or a substance abuse professional with one year of full-time, post-graduate degree accumulated supervised experience in alcoholism and drug abuse counseling; or
 - a graduate of college or university with a bachelor’s degree in a human service field and two years of full-time, post-bachelor’s degree experience with the population served or a substance abuse professional who has two years full-time, post-bachelor’s degree accumulated supervised alcoholism and drug abuse counseling; or
 - a graduate of a college or university with a bachelor’s degree in a field other than human services with four years of full-time, post-bachelors degree accumulated mh/sa experience with the population served.

This category includes Substance Abuse Professional, Certified Substance Abuse Counselors (CSAC), Certified Clinical Supervisor (CCS), Licensed Clinical Addictions Specialist (LCAS) *

The full descriptions of categories of providers are found in the North Carolina Administrative Code

Supervision is provided as described below:

Covered services are provided to recipients by agencies directly enrolled in the Medicaid program which employ qualified professionals, associate professional and paraprofessionals. Medically necessary services delivered by associate and paraprofessionals are delivered under the supervision and direction of the qualified professional. The qualified professional personally works with consumers to develop the person centered individualized treatment plan and meets with consumers periodically during the course of treatment to monitor the services being delivered and to review the need for continued services. The supervising qualified professional assumes professional responsibility for the services provided by associate and paraprofessionals and spends as much time as necessary directly supervising services to ensure that recipients are receiving services in a safe and efficient manner in accordance with accepted standards of practice. The terms of the qualified professional’s employment with the directly enrolled agency providing service ensures that the qualified professional is adequately supervising the associate and paraprofessionals. The agencies ensure that supervisory ratios are reasonable and ethical and provide adequate opportunity for the qualified professional to effectively supervise the associate and paraprofessional staff assigned. Documentation is kept to support the supervision provided to associate and paraprofessional staff in the delivery of medically necessary services.

13.d. **III. Behavioral Health Rehabilitative Services**

A. Services under this section are provided by licensed practitioners or programs/agencies for the mentally ill, developmentally disabled and substance abusers certified as clinical addiction specialists and clinical supervisors meeting the program standards of the Commission on Mental Health, Developmental Disabilities and Substance Abuse Services; and who are directly enrolled with Medicaid. These services are available to categorically needy and medically needy recipients. They are provided under a sunset clause by certified or privileged staff of Local Management Entities (LME) directly enrolled with Medicaid. Services include the following:

1. Outpatient Psychotherapy (billed under CPT codes 90801 through 90857) found in the psychiatric code section of the CPT book. Service can be billed by all licensed clinicians according to their scope of practice.
2. Psychological Testing, Developmental Testing, and Neuro-behavioral Testing (described in section/billed under CPT codes 96100 through 96117). Services can only be billed by PhD and Master's Level Psychologist.
3. Behavioral Health Assessment* and Counseling as described in the HCPCS book, under the following codes:
 - H0031 (a non-physician assessment),
 - H0004 with multiple modifiers (modifiers are added to match CPT codes for group counseling, and for family therapy), and
 - H0005 (substance abuse group counseling).

** Certified Clinical Addictions Specialists (CCAS) and Certified Clinical Supervisors (CCS) can only bill for the three HCPCS codes identified above.*

13.d. **III.** Behavioral Health Rehabilitative Services (*continued*)

- B. All disciplines are licensed or credentialed by the State as mental health clinicians and can practice independently with oversight by their individual boards. Nurse Practitioners must have oversight by the Medical Board, while Licensed Psychological Associates must have supervision by a PhD to bill certain services. This type of requirement does not exist for the other disciplines. Certified/Licensed Clinical Supervisors (CCS) and Certified/Licensed Clinical Addictions Specialists (CCAS) requirements have been approved by the Division of Mental Health/Developmental Disabilities/Substance Abuse Services and are able to practice independently to provide counseling services only.
- C. Behavioral assessment and counseling codes may be billed by all clinicians. CPT codes or counseling codes should be used to define services provided not based on discipline.
NOTE: Certified/licensed substance abuse professionals cannot bill CPT codes.

14.b Services for Individuals Age 65 or Older in Institutions for
Mental Disease

(1) Inpatient Hospital Services

The state agency may grant a maximum of three administrative days to arrange for discharge of a patient to a lower level-of-care. With prior approval by the State Medicaid Agency, the hospital may be reimbursed for days in excess of the three administrative days at the statewide average rate for the particular level-of-care needed in the event a lower level-of-care bed in a Medicaid approved health care institution is not available. The hospital must, however, make every effort to place the

recipient in an appropriate institution within the three day administrative time allowance.

(3) Intermediate care facility services.

(a) Prior approval is required in the following circumstances:

- (1) All admissions to intermediate care facilities.
- (2) All utilization Review Committee recommendations that require change in the level of care; however, these recommendations will be taken into consideration at the time of review.
- (3) Patients seeking Title XIX assistance in an intermediate care facility who were previously private pay or insured by a third party carrier.
- (4) When a patient is discharged from an intermediate care facility to a lower level of care or to his own home, and later returns to a level of care that requires prior approval.
- (5) When a Medicaid patient's benefits are terminated for 90 days or more before reinstatement, even though the patient remains in the same facility.

(b) Circumstances that DO NOT Require Prior Approval for Intermediate Care:

- (1) An approved patient who is hospitalized and returns to the previously approved level of care.
- (2) An approved ICF patient who leaves the facility for an overnight stay provided the absence is authorized by the attending physician.
- (3) The Independent Professional Review Team recommends a change in level of care. These recommendations will be accepted.

- (c) The form approved for ICF placement is valid for 60 days. If a patient has not been placed during this period of validity, the state or its designated agency should be contacted. At this time, the reviewing nurse will re-evaluate the form and determine if more current information is needed.

15. Intermediate Care Facility Services

Limitations and prior approval same as described in Item 14.b.(3).

- a. Intermediate Care Services Including Such Services in a Public Institution for the Mentally Retarded

Limitations and prior approval same as described in Item 14.b.(3).

16. Inpatient Psychiatric Facility Services for Individuals Under 21

The state agency may grant a maximum of three administrative days to arrange for discharge of a patient to a lower level-of-care. With prior approval by the State Medicaid Agency, the hospital may be reimbursed for days in excess of the three administrative days at the statewide average rate for the particular level of care needed in the event a lower level-of-care bed in a Medicaid approved health care institution is not available. The hospital must, however, make every effort to place the recipient in an appropriate institution within the three day administrative time allowance.

Admissions for all out of state psychiatric hospitals including those enrolled as border psychiatric hospitals are subject to prior approval for necessity to go out of state. Services in out-of-state hospitals are provided only to the same extent and under the same conditions as medical services provided in North Carolina.

23.a. Transportation

Services provided by an ambulance provider under the Medicaid program must be demonstrated to be medically necessary and are subject to limitations described herein. Medical necessity is indicated when the patient's condition is such that any other means of transportation would endanger the patient's health. Ambulance transportation is not considered medically necessary when any other means of transportation can be safely utilized.

- a. Emergency ambulance transportation for the client to receive immediate and prompt medical services arising in an emergency situation. Emergency transportation to a physician's office is covered only if all the following conditions are met:
 - (1) The patient is enroute to a hospital.
 - (2) There is medical need for a professional to stabilize the patient's condition.
 - (3) The ambulance continues the trip to the hospital immediately after stabilization.
- b. Non-emergency ambulance transportation to and from a physician directed office/clinic or other medical facility in which the individual is an inpatient is covered in the following situations:
 - (1) Medical necessity is indicated when the use of other means of transportation is medically contraindicated because it would endanger the patient's health. This refers to clients whose medical condition requires transport by stretcher.
 - (2) Client is in need of medical services that cannot be provided in the place of residence.
 - (3) Return transportation from a facility which has capability of providing total care for every aspect of injury/disease to a facility which has fewer resources to offer highly specialized care.
- c. In order to claim Medicaid reimbursement, providers of ambulance services must be able to document that ambulance services were medically necessary.
 - (1) The UB-92 claim form must describe the recipient's medical condition at the time of transport by using appropriate condition codes to demonstrate that transportation by any other means would be medically inappropriate.
 - (2) A legible copy of the ambulance call report to support the condition codes used must be kept on file by the provider for five (5) years which indicates:
 - a. the purpose for transport,
 - b. the treatments,
 - c. the patient's response; and
 - d. the patient's condition that sufficiently justifies transport by stretcher was medically necessary.
- d. Prior approval is required for non-emergency transportation for recipients to receive out-of – state services or to return to North Carolina or nearest appropriate facility.

23.d. Skilled Nursing Facility Services for Patients Under 21 Years
of Age

Limitations and prior approval same as described in Item 4.a. Skilled Nursing Facility Services.

23.f Personal Care Services

- a. The number of hours of personal care services received by a Medicaid beneficiary may not exceed 3.5 hours per day and sixty (60) hours per calendar month. If a Medicaid beneficiary demonstrates the need for personal care services in excess of the 60-hour monthly limit, nurse case managers employed or contracted by the State may authorize up to 20 additional hours per month for each eligible beneficiary. The 3.5 hour per day restriction does not apply to Medicaid recipients receiving hours above the 60-hour/month limit.
- b. Licensed home care agencies are enrolled for Personal Care Services rendered in private residential settings. Personal Care Services may only be rendered outside of private residential settings in order to assist eligible individuals with obtaining and maintaining competitive employment. The agency must be a State licensed home care agency that is approved in its license to provide in-home aide services within the State. Licensed home care agencies are required to perform the following activities to comply with state laws:
 - 1. Complete background checks on all employees,
 - 2. Conduct in-home aide competency evaluations and trainings,
 - 3. Monitor quality of care,
 - 4. Handle Workers' Compensation,
 - 5. Manage the payment of income and Social Security taxes, and
 - 6. Ensure that in-home aides work under the supervision of a Register Nurse.
- c. All Medicaid beneficiaries residing in licensed domiciliary care facilities receive Personal Care Services provided by the facilities. The Division of Medical Assistance contracts with each facility for the service. Licensed domiciliary care facilities are public or private non-medical institutions.
- d. The need for enhanced personal care services beyond the amount of one hour per resident day in the basic (capitated) rate for domiciliary care facilities is based on a case manager's evaluation of a resident's care requirements for extensive or total assistance in eating or toileting and must be authorized by a physician.